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ABSTRACT

The study involving 130 teachers investigated the elements of psychoeducational evaluation seen by teachers as most helpful in working with emotionally disturbed children. Ss responded to questionnaires which delved into physical, psychological, social-emotional, moral-ethical, and mental development of the child. Results revealed that the greatest number of teachers considered the psychological and physical aspects of development to be most important in terms of need for information relevant to the teaching role; while moral-ethical and social-emotional aspects were considered of lesser importance. Implications based on study findings included that medication is sometimes an absolute necessity for behavior control acceptable in the classroom, that a positive approach should be maintained whenever possible to aid the child in building a positive self image, and residential treatment gains made by the children may be lost if adequate followup is not provided. Further implications were that the psychologist can provide for the teacher of the seriously emotionally disturbed children only that information which the teacher has specifically pinpointed. Time saved in unnecessary testing can be more effectively utilized by discussion of the findings with the teacher, interpreting, and when necessary, explaining how the findings can be interpreted in terms of value. Among appendixes are regulations of the seven states from which Ss came, a report on chemotherapy and behavior modification, and random samples of teacher comments. (SBH)

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ABSTRACT

A STUDY OF HOW TEACHERS OF SERIOUSLY EMOTIONALLY DISTURBED CHILDREN CAN DERIVE BENEFIT FROM A PSYCHOEDUCATIONAL EVALUATION BY A PSYCHOLOGIST

by

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A Dissertation Submitted in Partial Fulfillment of
The Requirements for the Degree of
Doctor of Philosophy

WALDEN UNIVERSITY

April, 1980

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Results

A significant difference was found in the mean responses of the one hundred thirty teachers for the mental, physical, psychological, social-emotional and moral-ethical aspects of development. A significant difference was also found in the way teachers respond to individual items; the responses were not found to be equal, but independent of the state in which the teacher was employed.

Implications based on the findings of this study indicate that the psychologist who serves seriously emotionally disturbed children, can provide for the teacher in any setting, that valuable information which the teacher has pinpointed specifically.

The selection of appropriate tests combined with other techniques has refined the diagnostic process.

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CERTIFICATE OF APPROVAL

PH.D. DISSERTATION

This is to certify that the Ph.D. dissertation of

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has been approved for the dissertation requirement for the Doctor of Philosophy degree at the July, 1980 graduation

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CHAPTER I
INTRODUCTION

A child is born with basic psychological and physiological needs which are interrelated. Fulfillment of these needs is essential to survival of the organism in the environment outside the womb. These needs may vary in degree of intensity but not in kind. The need for food, warmth and comfort are basic to all children.

Since a child cannot exist by himself, he becomes a social individual and the development of his personality depends in part on genetic factors and in part on behavior learned in his basic family group. Any individual in the environment who is instrumental guiding the child to satisfaction of his basic needs is providing cues and reinforcement for responses to that specific environment; thus both desirable and undesirable behaviors are learned. The longer a basic need is fulfilled by the exhibition of a certain type of behavior, the stronger and more integrated it becomes within the developing organism. Through each developmental stage of feeding, toilet training, sex development and mobility, certain kinds of behaviors evoke very strong feelings and reactions in the people who witness them, ie. fear, anger, sadness, happiness. The child may acquire any of these observed behaviors either by modeling or by testing for response.

Leo Kanner, in Child Psychiatry, defines frustration as a motivating factor in emotional problems which takes place when an unsurmountable obstacle is encountered on the way to the attainment of a desired goal. (1948,p.179). More recently, Harry Harlow et al., have stated in Selected Readings in Human Development, Social Behavior of monkeys, a high level of aggressiveness in primates is simply a mechanism for reacting to need frustration. Harlow defined "rage" as the attack drive which matures earlier in some species than "fear". (Haimowitz and Haimowitz, 1966,pp 230-234).

If babies could talk, they would tell their own stories of frustration. Aggression is the most frequent defense which the human organism has at its disposal in the struggle against restraint.

The "Special Children" with whom this study is concerned are those children who have acquired such severe maladaptive behavior that they have been categorized as emotionally disturbed.

Background Information

The emotional problems of children housed within the confines of a children's Unit of a Mental Health Facility are serious in nature and require the full services of a treatment team. The composition of the team usually consists of a Psychiatrist, Social Worker, Psychologist, Occupational Therapist, Teachers, Recreational Therapist and aides. Intake reports on the children revealed involvement in such acts as glue sniffing, fire setting, runaway, self abuse, car theft, vagrancy and extreme cruelty to others.

Educational programs utilize the teaching skills of unit staff and the school program must provide both educational and therapeutic experiences which will correlate with total treatment activities.

A child with severe personality disturbance is often capable of displaying a range of extreme behaviors from complete withdrawl to overt aggression, thus it is of value to the psychologist to know what specific behaviors the teacher in the classroom has observed and the conditions under which these behaviors occurred.

Historically, the teachers have provided more daily contact in terms of clock hours spent with students than other members of the treatment team. For this reason relevant valid information can aid the psychologist in selecting appropriate tests, thereby eliminating unnecessary testing.

The psychologist can then provide valuable psychoeducational information for the teacher whose goal of classroom adequacy most frequently is the eventual return of the student to public school.

Subsequently, the student who has responded to inpatient treatment at a mental health unit and returns to a public or privately based special education program needs the services of a treatment team member; ideally the psychologist. The interpretation of "what has happened in the child's program," must be made in language that is meaningful to the teacher, and in strategies that are reasonable and feasible in the public school or other setting, if the child is to retain the benefits derived from residential treatment.

In most cases teachers who have requested in-depth diagnosis and treatment need assistance in interpretation of the findings and in planning the total follow-up program for the student.

Assistance from the psychologist is also beneficial to the teacher of regular class with integrated students who are experiencing emotional difficulties and to the teacher of students receiving mental health treatment services on an out patient basis.

Issue

Severe personality disorders in children fall into a broad category of classification of mental disorders and vary in causation as well as degrees of intensity. Some conditions are related to measurable, visible organic nervous system disease; some are only visible when portions of the brain can be examined under a microscope. Next are those conditions that are termed serious to total disorders of the personality. Here, no physical cause can be seen when examining portions of the brain under a microscope. The common ones frequently found are the schizophrenias, and the emotional disorders such as affective disorders of psychoses, the manic depressives, and the involuntary depressive illnesses.

The psychoneuroses, disorders of behavior where part of the personality is troubled were considered. These children, in many respects were in good touch with reality, and it was only in certain areas of their functioning that they were limited or handicapped. When causal factors were identified and treated, the individual succeeded satisfactorily in school and in life.

A brief investigation was made of the behavior disorders of childhood and adolescence which may develop, under environmental stress conditions, into extreme cases of juvenile delinquency and acts of violence.

Any child with special problems is entitled to the best available resources which will allow the differential diagnosis of disabilities needed to provide a basis for a treatment program.

Statement of the Problem

The present study was undertaken to obtain and to identify useful information concerning the roles of two particular members of the psychiatric or diagnostic team, the teacher in the classroom and the psychologist functioning in a psychiatric setting or serving students with severe emotional problems in public and/or private schools.

It sought to answer the following questions:

(1) To what degree do teachers of seriously emotionally disturbed children consider information about the physical, mental, psychological, social-emotional and moral-ethical aspects of development relevant to his/her role in the education of the child referred to the psychologist for evaluation?

(2) Are the teachers' responses independent of the state in which they are employed?

(3) Does a teacher prefer a written report of testing and assessment with appropriate recommendations or does s(he) prefer a written report combined with two-way communication and discussion of results?

The Purpose

The purpose of this study was to determine what type of psychoeducational information teachers of emotionally disturbed children viewed as most valuable.

This study obtained diverse, diagnostic information by using a psychoeducational questionnaire which provided cross-sectional analysis of developmental aspects of the child, ie. physical, mental, social-emotional, moral-ethical, and psychological.

The teachers responded individually to questionnaire items in terms of their training and experience.

Information derived from this study extends existing knowledge related to how teachers view child service needs information provided by the psychologist.

Need for the Study

The cause of Special Education since its induction into the Public Schools in the 1960's has been a dedication of service to the child with a handicap.

But how has the child with a handicap been identified? Martmer (1959), suggested that a handicapped child is any child with a physical, mental, emotional or psychological problem which interferes with normal growth and development. This definition emphasizes the child as a whole individual with needs and environmental presses which are no different from other children. Murray (1938) stated that adequate fulfillment of these needs within a purposeful learning environment will allow for the development of the true potential of each child. Piaget (1969), has described mental growth as being inseparable from physical growth, and that maturation of the nervous and endocrine systems continues at least until the age of sixteen. Environmental influences assume increasing importance after birth, and each period of a child's development partly explains the periods that follow.

The order of development of the sensory motor system growth of the newborn is constant from perception through the symbolic stage, although the average ages vary with the individual according to his degree of intelligence or his social environment. Every acquisition of the child in terms of learned behaviors from the simplest to the most complex, may be considered as a response to stimuli in the external environment; however, the response may or may not be related to the developmental problem.

Today, due to advances in medical knowledge, thousands of children survive who would have died at birth or shortly thereafter a decade ago. However, many of these children are found to have pre-natal or post natal developmental eye and ear defects, congenital heart lesions, orthopedic defects, various types of brain damage or central nervous system weakness. Identification of the problems at a very early age, followed by a multidisciplinary approach to differential diagnosis, is highly important to the care and treatment and psychoeducational planning of program for the child with a handicap.

Since accurate diagnosis and psychoeducational planning are so vital to program planning, increased skills should be required of the diagnostic team members. Yet, in a recent survey of the trends in graduate training programs for school psychologists, Clair (1971) reported that teaching experience and teaching credentials generally were not required for school psychologists enrolled in training programs of ninety-six colleges and universities of the United States. In his survey, Clair pointed out that a careful blend of both psychology and education would increase the diagnostic skills and services rendered by psychologists who served programs for handicapped children.

The teacher, a vital and contributing member of the care and treatment team, plays an important role in helping to pinpoint observational behaviors that a psychologist will recognize as symptoms requiring specific treatment. The role of the teacher functioning in an interim setting or in a public school setting requires that s(he) be cognizant of the intricate relationship between intense emotional feelings and intellectual functioning.

It is also highly desirable that the child be viewed as a developing, "whole organism" considering the relationship among physiological, psychological, social-emotional and moral-ethical aspects.

As Friarson, (1967) stated, the term, clinical education, used to convey the notion of educational procedures based on a thorough clinical evaluation of the child, denotes educational procedures based upon evidence from several disciplines.

Clinical education must differ from regular education in a positive manner if the investment in a multidisciplinary approach is to be justified. The thoughts and approaches of Piaget (1960), on the problems of perception could be considered as very valuable in understanding the child who is presenting an emotional or educational problem due to difficulties in perception.

Many teachers, both inexperienced and experienced have had a tendency to focus on curriculum content, assignment procedures, and rigid control rather than on direct observations and planning of programs adaptable to the level of frustration tolerance of the child, his interests, his aptitude and attitude toward school related material. Johnson and Myklebust (1967) , stated that, "With the emotionally disturbed, remediation is planned along the lines of lessening the demands as their affective tolerance warrants. The process is one of bringing about greater acceptance of reality, development of insight and strengthening of ego functions." Thus consideration must be given to a child's feelings of success or failure in the school program. Glasser (1975) , in Schools Without Failure, vitalized the concern for child progress in the classroom as it relates to continuous development of a positive self-image.

Teachers need to be cognizant of ways to aid a child in achieving success related positive self-image. Working with a skilled psychologist in a cooperative manner can provide the teacher with information about the child which can be transferred to success producing psychoeducational programs and activities.

The utilization of a cross-sectional technique, ie. the avoidance of simple concentration on one diagnostic method, provides the psychologist with a unique method for obtaining diverse information valuable to the teacher for writing the psychoeducational prescription. Peter (1968). Information from cross-sectional data may also be useful in the development of an appropriate formula for behavior modification of deviant, socially unacceptable behavior. (Bandura, 1969). Information derived will be valuable not only to the teacher, but to other members of the treatment team including the psychiatrist.

The long range goal of the treatment team is to restore good mental health, or to help the child gain a strong enough self image to function adequately in his native or selected environment. Persons working with the child upon release from a hospital setting to a public or private school or homebound program need vital psychoeducational information to insure the child's continuous progress.

Summary

Of vital importance to the habilitation or rehabilitation of the child who is seriously emotionally disturbed , is a series of meaningful interactions between the psychologist-teacher team and the child, as well as between the psychologist and the teacher. Information and communication relevant to both the diagnosis of the problem and planning of follow-up program may be obtained most effectively in this manner.

The use of a standardized psychoeducational questionnaire composed of items relevant to the "total development" of the child will make a cross section analysis of aspects possible. Information derived will be meaningful and the amount of time required to obtain results will be reduced.

Definition of Terms

ambivalence- Coexistence of equally strong, opposite emotional attitudes toward a given person or object

appetency- the tendency of one thing toward another

blocking- difficulties in memory or in other intellectual processes due to emotional reactions which are often unconscious.

coerciveness- forcefulness; compelling movement

conflict- conditions brought about by tensions which combine and become more or less sharply opposed along the lines of two or more components.

convulsive- involuntary spasm or contraction of a muscle

cyclothymia- manic depressive psychosis

depression- reduction of vital or functional activity; in psycniatry, diminuation of mental and physical activity.
(emotional) depression- undue sadness or melancholy
(agitated) depression- depression with anxiety

diffusion (natural)- diffusion in the social context refers to the spread of the adoption of an innovation.

ego- the part of the mind or psyche which possesses consciousness and which is engaged in testing reality

emotionally disabled- unable to establish and maintain satisfactory interpersonal relationships

hallucination- condition considered to be a symptom of serious mental disorder in which a person actually experiences as a real perception, what in fact has no corresponding stimulus in the outside world

id- Freud's term for the instincts as a totality; the true unconscious

inappropriate behavior- behavior consistently outside the realm of acceptability, in a given situation isolable- separated or set apart

libido - psychic drive or energy usually associated with the sexual instinct

M-team - Multidisciplinary team ; functions in the process of determination of child needs, programs and follow-up services. The composition of the team may depend on the handicapping condition under consideration and may include professionals, para-professionals or community resource persons.

manic- violent excitement in a disordered mental state

manic depressive - condition marked by alternating mania and depression; a functional nervous disorder; especially a minor psychotic reaction characterized by disorientation; often characterized by personality disorder.

nucleus - a mass of gray matter in the central nervous system especially such a mass marking the central termination of a cerebral nerve.

pathogenic- disease producing agent

physical - relating to the body

physiological - dealing with all the functions and activities of living things

psychopathological - relating to diseases of the mind

resource systems- interrelated sets of people and organizations capable of providing resources.

schizophrenic- term for large groups of psychoses of a psychogenic origin characterized by disorientation, loss of contact with reality

stress- tension that is internally produced and arises out of structural arrangements of the system.

sublimation- socially approved modification

surrogate - one who takes the place of another in a person's affective existence

trauma - injury to the subconscious mind by emotional shocks which may produce a lasting effect.

CHAPTER II

REVIEW OF RELATED RESEARCH

A review of the literature indicates developmental growth of the organism with personality development influenced by both pre-natal and post natal environmental factors.

Personality Development

Davis and Havighurst (1943), thought of personality as a bundle of learned responses and genetic factors of organic growth; the cultural aspect of personality, they said, are the responses learned in conformity with the demands of the family group. The individual aspects of personality include genetic and all other traits which distinguish among men who have been trained in the same culture but whose responses to this training have varied according to the particular condition under which the training took place. Menninger (1957), used the term "personality" as meaning, the individual as a whole, his height and weight, loves and hates, blood pressure and reflexes, smiles and hopes. He meant all that anyone"is" and all that he is trying to become. The more specific components include an inherited nucleus of physical and psychological potentialities probably confined to physical structure including brain patterns. Menninger contended that whatever nucleus is inherited is soon acted upon by such powerful influences as parent teaching, reaction to siblings, climate and weather, the architecture of the home, the food, clothing, influence of school, playmates, economic and social laws, and accidents of life. Additional influences on the genetic nucleus include, but are not limited to such factors as physical and mental illnesses, griefs, shocks, disappointments and achievements.

Mussen, Conger, Kagan (1956) , viewed personality as a continuous, highly complex process involving the interaction of a biological organism with its physical, psychological and social environment. These authors contended that no two individuals will ever develop identical personalities due to the interdependence of the physical, emotional, intellectual and social components of the complex developmental process. Thus emotional factors may affect physical health, while emotional adjustment may influence intellectual performance. Kessen (1979), pointed out that due to the viable contemporaneous cultural forces of single parent families, day care centers, division of child rearing responsibility in two parent working families, psychology's child of today must be viewed as a free standing agent- an isolable being who moves through development as a self contained and complete individual.

The proper unit of cultural analysis and the proper unit of developmental study is the child alone, with the recognition that other self contained people such as teachers and parents have influenced the development. It is difficult to imagine an American child psychology without a core commitment to the proposition that someone is responsible for what happens in the course of development.

Hoffman (1979) reported a marked increase in the number of working mothers of pre-schoolers. She stated that almost 42% of this group are now employed. Employment rates are higher for single-parent families and single parent families are also on the increase. In short, maternal employment is now the modal pattern and there is every indication that this trend will continue (U.S. Department of Commerce, 1979). This is an important social change affecting the individual child in some manner.

Ross (1979) contributed additional information relevant to changes which have emerged and the effect these changes have made on the study of social-emotional development of children:

1. The child is actively involved in his or her own social development via bi-directionality in which the child and adult influence each other
2. Since social-emotional development has multiple causes, multiple theories are necessary to understand it, such naturalistic observation in addition to the full range of research strategies.
3. In order to understand social-emotional development, multiple levels ofsocial influence must be investigated
4. Social-emotional development is context bound and agent bound, ie. the child exhibits shifts of behavior across

social agents or partners and in multiple settings

5. Social-dmotional adjustment and development is culture bound

6. Research on social and emotional development is influenced by social policy

7. Social-emotional development is affected by secular trends

Lamb (1979), investigated the influences of the Father and he concluded that the Father is primarily responsible for initiating sex-differentiating treatment, channeling the direction of the child's attention toward the behavior of the same sex parent. The children, especially boys develop preference for the same sex parent. (Money & Ehrhardt, 1972) reported that children acquire a sense of gender identity during the first two years to three years and that boys, raised without fathers tend to manifest gender role deficiencies. These " effects of Father absence " are especially likely when the Father is absent during infancy (Biller, 1974).

Since there is no separation, but rather continuous interaction between intelligence, emotion, childhood social influences and biological development, isolation of the concept of "emotion" for scientific study has been limited .(Kerlinger,1973). Yarrow (1979) alleged that emotions cannot be understood by obtaining the viewpoint of an outside observer, but requires input from the individual about his feelings.

Emotion has been defined by Little (1959) , as a " mental feeling that is distinct from cognition; a moving, stirring, agitation." Little states that both sexes have a full compliment of feelings. The emotionally healthy individual is one who understands and accepts his emotions as essential and an important part of himself, who uses them appropriately in life situations by neither giving way to them excessively, nor by attempting to deny their existence. A comprehensive definition of emotion based on Aristotelian classification considered by Bittle (1944) , pointed out the variability in kind, quality and degree. His definition suggested an affective mental state of the organism following the cognition of an object or a situation characterized by strong feeling, impulse to action and/or physiological changes in body function. Bittle described two appetency or passion emotions which are primary and fundamental: "love of good and hatred of evil." This *love and hatred* may be referred to present or absent objects; thus there are corresponding emotions of *desire* for an absent good, *aversion* of an absent evil, *joy* with a present good, *sadness* at the loss of good or presence of evil, *hope* for possible attainment of good, *despair* of the impossible attainment of good, *courage* in situations of threatening, unavoidable evil, and *anger* against the presence of an evil already befallen the organism.

Redl (1959) , stated that an emotionally well child is unusually happy, is able to make substitutions to obtain some need gratifications, displays an appropriate range of emotions, has reasonable control over behavior, is sensitive to the needs of other people and is able to communicate with others to seek help when needed. An emotionally well child is effective in work and play, has a good appraisal of reality, is able to deal with mistakes by making amends and doing better, has self-confidence under stress, and can make plans for the future.

Royce (1965), listed three concepts often used to judge both the emotional needs of individuals and the results of efforts to aid people: "adjustment, maturity and normality." Adjustment represents the ability of an individual to live harmoniously with his environment and himself, Maturity is relative to age and environment; behavior is mature when it is appropriate to age level, problems and setting of the individual. Normalcy is behavior expected of an individual under the conditions which he confronts.

A brief review of learning theorists seems highly relevant to personality development: Thorndike, in 1913, proposed the law of cause and the law of effect in determination of behavior; Watson and Guthrie (1928) , were contingency theorists, contending that stimulus-response bonds are simply strengthened by the response occurring in the presence of the stimuli. Skinner (1956) regarded punishment as a poor method of controlling behavior due to adverse side affects: he operated on the principle of response to stimulus toward reward, shaping behavior through a series of successful approximations, each made possible by selectively reinforcing certain responses and not others. Dollard and Miller (1950) felt that individuals were motivated by "drive" and they placed more emphasis on "drive" than Skinner. They defined drive as an arousal state which goads the individual to action. Their theory was that drive, either external or internal, produces a response to a cue resulting in a reward; removal of the drive decreases activity. Tolman (1952) felt that individuals do not simply respond to stimuli, but act on beliefs, attitudes, and goals; his theory is a theory of purposive behavior. Lewin (1966) , studied the goals and desires of an individual directly in relation to personality, searching for a system for valid prediction of motivated behavior. In his concept of "life space", the person, the goals he is seeking, the negative goals he is trying to avoid, the barriers that restrict his movements, and the paths he must follow to get what he wants, determine the behavior of a given individual at a given time. McClusky (1975) offered a theory of power relations in terms of influencing beneficial changes , and the behaviors in which people elicit changes in terms of their legitimacy, coerciveness and adversity for the target (recipient). The significant differences in the ways which "power" as a core word in the political vocabulary may be termed as authority, persuasion, coercion, force, domination, leadership etc.

Yarrow (1979), proposed that the study of emotions should not be isolated from feelings. He suggested the need for more study on the relations between early childhood emotions and later adaptation. He stated that while much adult pathology may be traced to intense emotional experience in infancy, ample information has not been obtained on the conditions associated with positive emotional outcomes and the means by which a child develops positive feelings about himself or herself. Positive self evaluation is undoubtedly associated with the ability to control the environment. Theoretical thinking on effectance motivation (White, 1959, Hunt, 1965) emphasized that there is an intrinsic motivation for competent behavior.

Plutchik (1980) , outlined a broad theory for understanding and classifying emotions. The theory defines an emotion as a complex series or sequence of events having elements of cognitive appraisal, feeling, impulse to action, and overt behavior, all of which are designed to deal with the stimulus in the first place. Plutchik stated that the nature of the environment creates functional requirements for all organisms if they are to survive and viewed the emotions in terms of usefulness to the organism to increase chances of survival. Plutchik deduced that the eight primary emotions are: fear, surprise, sadness, disgust, anger, anticipation, joy, and acceptance (receptivity). He chose these because he felt that they displayed a certain internal consistency and addressed a wide range of issues regarding emotions and personalities as they relate to chances of survival.

Significant conceptual and methodological advances have been made since the beginning of the century when William James (1890) initiated a long enduring controversy about the nature of emotions. The collection of many relevant data has resulted in considerable progress.

Regardless of the theory of learning in relation to the development of personality one accepts, well documented research indicates that each individual is unique and that the degree of satisfaction he derives from a motivation toward a basic need of food, shelter, security, belonging, or love and affection, can hasten or retard the learning process immeasurably. Menninger(1949), Martmer (1959), Glasser (1965), and Mussen, Konger & Kagan (1965), agreed that the child accepts learning provided that it is accompanied by certain tangible satisfactions, but when he is thwarted or severely restricted, he may abandon the effort to please his identification models. Smith (1969), also agreed with Menninger and others contending that the personal, social and emotional aspects of a child's makeup profoundly influence school attendance; he further states that, "problems of social adjustment may reduce the child's overall ability to learn."

Rosenblatt (1966), reminded investigators of the defense mechanisms used by even very young children in their attempts to satisfy basic needs. He cited the use of polar opposites:

love-hate,cruelty-pity, as examples of substitutions to relieve anxiety. Rosenblatt saw each child in a cognitive, emotional, sexual sense and emphasized the ways in which sexuality intervenes in the growth of ego functions.

Gordon (1959) , emphasized that the personality grows or develops as the individual organism acquires attitudes and values, learned through time in the family circle; such concepts as comfort and control, security and satisfaction, develop in relation to the behavior of people in the child's culture.

Thus, says Gordon, as the child grows, his external and internal self is constantly changing as he reacts to the environmental forces which control his basic needs.

This feeling of self or body image in the environment is determined by body physique, measurement of self against others, and the constitutional makeup of the child. His knowledge is sometimes unreliable, his understanding may be incomplete and his behaviors are constantly being tested in each new learning experience.

Caldwell (1967) , examined the validity of the premise that there is only one effective learning environment for every child - an intra family environment characterized by minimal disruptions in primary social relationships, a warm, stable mother, and a necessary pattern of sensory stimulation. The conclusions she derived indicated that such an environment produced developmental results superior to institutions and foster home care. Caldwell also considered the large number of children for whom family resources are not available and for the children whose mothers demanded professional help. Alternatives for traditional home care were needed due to the inability of some mothers to cope with full time child care responsibilities and others concerned with employment. Caldwell concluded that any growth fostering alternative environment must include warm, nurturing, responsive people, who enable a child to progress from where he is, to where he needs to go developmentally. The environment must be free from disease and pathogenic agents, and the program must be individual, with activities designed to promote continuous, spiral,total growth. Caldwell's investigations suggested that short term separations of the child from the mother need not be detrimental but may allow for White's (1959) , concept of competence as a major source of the stabilizing force in personality development.

Is it unrealistic to search for an optimal learning environment or an ideal situation for the developmental learning of the young child? Allers (1951) , contended that in the genesis of the personal ideal,(what he called the "character ideal") , decisive importance attaches to the figures of the parents who set a pattern for modeling trust, values of right and wrong, truth, and understanding through each developmental stage from infancy to adulthood.

Such psychological functioning involves a continuous, reciprocal interaction between behavior and its controlling conditions ; and, as Bandura (1969), stated, In social learning the actions are regulated by behavior consequences, and the controlling environment is often altered by the behavior.

Disturbed Personality Development

One of the most important questions one can ask about disturbed personality or emotional and social maladjustment is how it came about.

The etiology of the emotionally disturbed child is probably more complex than for any other type of exceptional child.

Dollard and Miller (1950) , proposed, as did Freud, that intense conflicts are the basis of behavior pathology. By conflict, they meant two or more incompatible drives such as: hunger, fear, sex, or anger. These researchers contended that the child is particularly vulnerable to stress in the drive for basic need satisfaction during the critical training periods of feeding, cleanliness related to body waste elimination, sexual attachments as learned behaviors and anger as related to punishment.

In the feeding situation, a child cries in response to the hunger need; if fed he learns to control his outside world. If he is not fed while crying, and his hunger is allowed to mount, violent crying becomes his basis for reward and he learns to over-react. If not fed, and left to cry it out, the child may become apathetic and listless and not try to control his environment when in trouble. If punished by spanking or harsh words at feeding time, a child may develop a hunger anxiety. If the child's elimination of body wastes incites parental punishment, development of tensions, fear of losing security and parental love may occur. The child attempts to avoid punishment; sometimes he is unable to differentiate between parental dislike for an act committed and total rejection, which may be extremely ego damaging. As a result of trying to satisfy parents, he may conform excessively while developing feelings of insignificance, resulting in later life in some form of psychic guilt. Although hunger, pain and fatigue are cited by Dollard as ranking higher in human primary drives than sex, inhibitions associated with the sex drive produce more conflict situations. Sexual behavior, like all behavior is learned. The critical training area investigated earlier by Dollard(1939) , viewed punishment related to anger as vital since society attempts to repress and inhibit violent responses. Most parents intuitively resent and fear anger and rage which the child may have learned as a response do frustration during the feeding stage, in sibling rivalry or due to mental limitations of comprehension. If anger, as a reaction, is removed or suppressed, other mechanisms of defense such as deceit, gossip, evasion or withholding love may result.

Millon (1969) , stated that Freud's foundation of intrapsychic theories could be viewed as civilized and social phenomena reduced to biological instincts. Mental disorders, according to Freud, arose as a result of conflicts and frustrations of these instincts. Freud (1920) , resolved that sensory stimulated stages of sexual excitation, developing from the infancy period through early childhood, adolescence and puberty,could develop into lifelong character disorders if frustration, conflict, anxiety or ego damage occurred during any or all of the progressive periods. For example:

1. A child subjected to forced feeding who submitted rather than lose parental support may become a cautious, acquiescent person unable to step forward to gain adult independence. This early pattern would force retreat whenever faced with high anxiety. Psychosomatic ailment may arise from failure to attain certain goals; the individual would return home to security,turn to excessive eating, drinking as a regressive mode of oral satisfaction. Frustration experienced at the biting stage might lead to development of aggressive oral tendencies such as sarcasm and verbal hostilities in adulthood.

2. Difficulties associated with the toilet training period in relation to a feeling of pleasing or displeasing adults may develop into compulsive cleanliness and orderliness or rebellious disorderliness. Rage and anger, a defense mechanism often employed by the child during this period, if successful in controlling parents, may continue as a life long pattern of self-assertion, and negativism.

3. Conflicts during the phallic stage, characterized by interest in the genitals and manifested in masturbation, sexual curiosity and exhibitionism may become fixed if unresolved and present lasting difficulties in the development of healthy, normal sexual relationships.

Clardy (1951), in his studies, exposed much psychosis and serious maladjustment in children whose parents are over-supervising, over-possessive, over-anxious or domineering in their child rearing practices.

Bowlby (1952), from his overview of research on the etiology of the emotionally disturbed child, concluded that separation from the mother figure after possibly three to six years of age produces extensive and permanent effects on the personalities of some of these children in that, like psychopaths, they are not capable of relating effectively to others.

Earlier, Spitz (1946), another investigator stated that casualties of death, severe mental retardation, or mental retardation with emotional illness resulted in children who were institutionalized from two weeks to twenty three months of age in 100% of the children studied; psychopathology resulted from the lack of consistent nurturing relationships with adults in early life. Spitz also suggested that Schizophrenia is the result of severe deprivation and/or lack of constant mothering in very early life.

Green (1946), investigated and reported on neurosis in middle class male children who were subjected to pressure in choosing between, " standing up for your rights," and "being a gentleman."

The inconsistencies in expectations led to neurosis due to greater postponements of immediate pleasure concerning their desires and home training in middle class values of "right."

Home conditions frequently are found to produce the causal factors of emotional disturbance in varying degrees for children who are vulnerable. Henry (1951), found that pathology of parental personalities transferred to children. Researchers including: Torrence (1945), O'Kelly (1949), Kanner (1951), Amos & Grames (1968), Chess & Thomas (1968), Bennis, Benne, Chin and Corey (1976), Kerlinger (1973), Hoffman (1979), documented these findings:

1. There is a strong relationship between poor family backgrounds, emotional problems and juvenile delinquency
2. Broken homes produce a higher incidence of cases of emotional disturbance, academic retardation and crime
3. Boys from broken homes showed more anger and destructiveness, were more self centered and more depressed than boys from complete homes
4. There is a tendency for the child to imitate the parent in order to comply with expectations
5. Children will readily yield to imitate an adult model who succumbs to temptation or produces deviant behaviors.

Sears (1966), discovered atypical patterns in boys whose fathers were prolongedly away from home during the early years. Kanner (1951), emphasized the incidence of emotional coldness in the genesis of early autism.

Another area which cannot be overlooked in any broad investigation of how emotional and social maladjustment came about, is the problem of organic deficiency found in some children. The makeup of the brain injured or neurologically handicapped child is influenced by underlying organic defects which result in a variety of both overt and covert disabilities. Psychiatric symptoms have been produced in the sensory deprived children who are subject to stress in the home and school environments. These children often develop distortions of self image which create body anxiety, depression, lack of motivation, and a reaction of varying degrees of maladjustment in the form of tics, stealing, assault, truancy, or withdrawl. Some of these children develop the type of symptom complex often termed, "psychopathic behavior with emotional instability."

It is difficult to define satisfactorily or to treat effectively, children who are disturbed, unless the home, family, and environmental backgrounds as well as the organic makeup of the child is thoroughly investigated and understood. Certainly it should be realized that any special or unique condition of a child causes him to be vulnerable to internal pressures and environmental influences.

Identification of Symptoms of Disturbance

Since homes that produce maladjusted and / or seriously disturbed children rarely investigate causal factors, the school or teacher is often the original referral source.

The report of the teacher's observations of a child's behavior can be invaluable in time saving help to the psychologist to whom the child is referred. The teacher in the regular classroom, the special education setting, or the institutional classroom will want to observe:

1. atypical behaviors
2. incidances of these behaviors
3. the experience situation in which the behaviors occur
4. the degree of intensity of the emotion displayed

Teachers in public school settings may observe students both individually and in groups and by early detection of symptomatic behaviors of emotional disturbance, refer the troubled child to a specialist for diagnosis and prescriptive treatment. Vigilance in observation is often requested of the classroom teacher by the participating psychologist or psychiatrist when a child is released from a treatment center and returned to the classroom in his local community.

Redl and Waterbury (1959) suggested that the difficulties which the teacher will note in school will usually be found in the areas of behavior, learning and/or physical or mental disability. The child who needs special help is one who has difficulties which persist for long periods of time and does not respond to the teacher's efforts. Some signals which might be significant and which should be investigated, if observed, are the following:

1. Behavior

   -lack of appropriate response to praise or punishment; some children seem to want punishment

   -chip on the shoulder attitude; unfounded, abnormal amounts of suspicion; imagining that someone is always against them

-exaggerated sensitivity to criticism

-tattling; troublemaking; does mischief and blames others

-faulty self image, i.e. not pleased with self; often degrading self

-compulsive conduct; striving for perfection

-inappropriate affect in general (laughs, giggles, cries, fears or does not show emotion)

-constant day dreaming

-notable depression

-marked fantasy

-periods of confusion alternating with normal periods

-unusually passive and conforming; worry about aggressiveness

-moodiness, sullenness, sadness

-negativism

-marked bravado; absence of fear or disregard for outcome

-insecure in the peer group; clings to the teacher

-cheating and subsequent denial

-stealing and lying

-quarreling, fighting, bullying or harming others

-responding to momentary impulse with destroying, fire setting, throwing things, acts of cruelty

-resistence to authority

-exaggerated desire to please

-frequent absences (school phobia)

-irrational fears

-marked hyperactivity; inability to concentrate, rocking, continuously shuffling of the feet, disturbing others, pulling things down, incessant talking, distractibility

-perseveration of an activity to the exclusion of others
-difficulty in climbing stairs

-refusal to eat; overeating

-disorganized or unpredictable behavior

-excessive fatigue

-desire to isolate oneself; does not relate to others

-bizzare ideas, behavior, drawings, motions, gestures, grimmaces,responses

-shifting behavior from seclusiveness to hyperactive behavior; vice versa

-mutism, communicates little; rare spontaneous speech

-marked immaturity

II. Learning

-inability to learn with usual teaching methods

-inability to work alone or with others

-marked variability in performance

-specific learning disabilities in reading, spelling writing, mathematics

-unusual learning patterns

III. Physical or mental factors

-exceptionally low intelligence; any child who is retarded academically at least two years indicates possible mental retardation and should be referred

-inadequate speech, inappropriate pitch or volume of voice; inadequate hearing-makes errors because directions are not understood

-poor vision; faulty vision of any type (crossed eyes,excessive movements, near sightedness) may cause rejection of board work activities involving reading

-chronic illness

-enuresis

-unusual physique-unusually tall, short, obese, disproportion of feet or head

-mixed lateral dominance i.e. right hand and left foot dominance or preference

-directional confusion

-drooling or motor awkwardness

-disturbances in orientation in space

-perceptual disorders-able to see parts but unable to combine them into wholes

-disturbances in concept formation (abstract thinking)
-the kind of thinking which allows for organization, group order, building relationships into meaningful patterns

-some neurological disorders
    -cerebral palsy-intelligence may or may not be affected and emotional disturbances may or may not occur
    -epilepsy- a syndrome consisting of brief seizures with possible loss of conscience
    -loss or impairment of language due to some type of brain injury
    -hyperkinetic impulse order or minimal brain damage-some degree of insult to the brain has caused changes in feeling, thoughts or behavior such as immaturity, poor motor coordination, poor speech, destructiveness, poor perceptual or conceptual abilities, anxiety, obsessive talking, defective memory, hyperactivity, distractibility, or other disorders.

There are many other symptoms of "unusualness," all of which cause the child to be vulnerable to emotional disturbance if the condition is not already present. In fact, one or more of the above mentioned symptoms occur in the same individual. For example, a child with limited mental ability may have difficulty in learning to read and may react to his feelings of frustration by displaying rebellious behavior.

Of vital importance is the attitude of the teacher with whom the child is in contact daily. This teacher must have the desire to understand and help the child.

Summary

The review of research involving the development of personality indicates that a multiplicity of factors are involved, including both genetic factors and learned responses. Both sexes have a full compliment of feelings, which, when understood and accepted by the individual, can contribute to good mental health.

The etiology of an emotionally disturbed personality involves the investigation of complex interactions between a developing organism and its encompassing environment. The individual learns to respond in ways which satisfy basic needs. Children from deprived environments, broken homes, those with poor physical and mental capacities and others who lack personal care or parental love are especially vulnerable to environmental stress and often react in some form of maladaptive behavior. It is well to remember that there is so separation, but rather continuous interaction between intelligence, emotion, social influences and biological change in the development of personality.

Problems of Learning and Behavior

Instructions: Thinking in terms of the child as an "organic whole being" and the Physical-Mental-Social-Emotional-Moral and Ethical factors involved in the thinking and learning process---Please check your opinion on the degree of importance of each item---as it relates to your better understanding of the child --and his Educational Program and Problems of Learning

	Not at all Important	Of little Importance	Sometimes Important	Usually Important	Always Important	
1. The intelligence quotient of the child.						_ MENTAL
2. The results of prior testing.						_ MENTAL
3. The educational implications of sub-test scores (WISC, WAIS, WPPSI).						_ MENTAL
4. The clinical significance of sub-test scores.						_MENTAL
5. Survey of communication and information processing skills.						_ MENTAL
6. Survey of problem solving skills.						_MENTAL
7. Reading comprehension and oral and written spelling ability.						_MENTAL
8. The nature of and limitations imposed by physical handicap.						_PHYSICAL
9. The medical diagnosis. The amount, kind and side effects of prescribed medication.						_PHYSICAL
10. The etiology of a child's speech problem.						_PHYSICAL
11. The measured degree of hearing loss and implications.						_PHYSICAL
12. The general physical health of the child.						_PHYSICAL
13. The degree of visual impairment.						_PHYSICAL
14. The laterality of the child and coordination.						_PHYSICAL
15. Overt aggressive behaviors: anger, destructiveness.						_PSYCHOLOGICAL
16. Withdrawal symptoms: shyness, fear, phobia, depression.						_PSYCHOLOGICAL
17. The child's reaction to male and female adult authority.						_PSYCHOLOGICAL
18. The social maturity of the child. Gross problem solving.						_PSYCHOLOGICAL
19. Social acceptance (peer group).						_PSYCHOLOGICAL
20. Value judgments: Ethical and Moral sense.						_MORAL_ETHICAL
21. Anticipatory response: foresight.						_MORAL_ETHICAL
22. The marital status of the parents or parent surrogate.						_MORAL_ETHICAL
23. The occupation of the parents.						— SOCIAL_EMOTIONAL
24. The birth order of the child.						_SOCIAL_EMOTIONAL
25. Sibling relationships in the home.						_SOCIAL_EMOTIONAL
26. The location and type of home dwelling.						_SOCIAL_EMOTIONAL
27. The number and relationship of people residing in the home.						_SOCIAL_EMOTIONAL
28. The race of the child.						_SOCIAL_EMOTIONAL
29. The church preference of mother and father.						_MORAL_ETHICAL
30. Does the child attend church services regularly?						_MORAL_ETHICAL

CHAPTER III

METHODOLOGY

Chapter III describes the procedures used in this study including these major topics: Selection of the Subjects, Methods of Collecting Data, Instrumentation, and Analysis of Data.

Subjects

Sample Population

The population for the study included full time teachers employed in psychiatric and school settings for seriously emotionally disturbed children of school age in the states of: Iowa, Illinois, Wisconsin, Delaware, New York Maryland and Pennsylvania. The total number of teachers included in the study was one hundred thirty.

Procedure

Two methods of obtaining data were utilized:

a. Sixty five, or one half of the total number of teachers responded directly to a standardized psychoeducational instrument and experience-training questionnaire during an appointment session which was made at their respective places of employment in the seven states.

b. Sixty five, or one half of the total number of teachers responded by mail to the questionnaires.

Teachers were requested to follow the instructions found at the top of the psychoeducational instrument: Appendix A.

> Instructions: Thinking in terms of the child as an "organic whole being" and the Physical (Ph.), Mental (M.) Psychological (Psy.) Social-Emotional (S.-E.) and Moral-Ethical (M.-E.) factors involved in the thinking and learning process. Please check your opinion on the degree of importance of each item ---as it relates to your better understanding of the child and his his Educational Program and Problems of Learning.

Teachers read the items and responded at their own rate; no time limitations were imposed.

This standardized instrument designed to include sample items related to the above mentioned developmental aspects of the child was considered to be cross-sectional in nature and relevant to this study. Items 1 through 7 (inclusive), considered the mental aspect, items 8 through 14(inclusive), the physical aspect, items 15 through 19 (inclusive) psychological, items number 20,21, 22, 29, 30 considered moral-ethical aspects, and items 23 through 28 (inclusive) social-emotional aspects. A sample can be found in Appendix A. The items selected were considered by Gesell, Piaget, Bayley, Valett, Goldstein,Glasser and others as highly relevant to the developmental learning processes of the child.

Informal interviews held with unit directors, assistants, and administrators concerning enrollment, methods of diagnosis, intake procedures and followup service yielded valuable information for discussion. The roles of two team members, the psychologist and teacher were especially considered.

Analysis of Data

This library-research/fact-finding study is reported in two sections for interpretation of data obtained.

In the first section, descriptive data are presented and are tabulated as frequency distribution mean scores and percentages. The second section presents inferential data using Chi square, α= .005)for teacher response vs state of employment, for each of the five categories of developmental items contained on the psychoeducational instrument. Analysis of variance was used on mean responses from teachers in the seven states, on each of the five categories in the questionnaire.

Results of teacher responses to training and experience are presented in tabular form for the purpose of discussion. A random selection of these responses was made in order to include an equal number from each of the seven states. N.= 5 from each state.

CHAPTER IV

RESULTS

Introduction

The results of the study are presented in this chapter. Several sections include data derived from teacher responses to the standardized research instrument composed of a cross-section of five aspects of child development, the personal data teacher questionnaire, and personal interview information. A copy of the psychoeducational questionnaire, the teacher questionnaire, a map of the areas included in the study and the number of teachers from each state, a list of the 30 items on the psychoeducational scale categorized into developmental areas and instructions may be found in Appendix A. Random samples of Northeastern and Middlewestern teachers personal opinions and comments may be viewed in Appendix F.

Historical data about psychological and philosophical bases for residential treatment of emotionally disturbed children, a discussion of issues and approaches involved in institutional vs foster home care of these children, and an appraisal of what various State Departments of Public Instruction are doing to implement PL: 94:142 may be found in Appendices B and C. Current thinking on the uses of chemotherapy and behavior modification as treatment methodology may be found in Appendix D.

A model plan for a comprehensive psychoeducational evaluation by a psychologist can be found in Appendix

Each question presented in Chapter I is discussed.

Permission to conduct the study was granted by the administrators, directors or department heads of the various schools, clinics or institutions included in the quest for teachers of seriously emotionally disturbed children.

One hundred thirty teachers responding to questionnaires included sixty five, or fifty percent from the Northeastern States of Delaware, Maryland, New York, Pennsylvania and sixty five, or fifty percent from the Middlewestern States of Iowa, Illinois and Wisconsin.

The teachers responded to thirty items related to the physical, mental, social-emotional, psychological and moral-ethical aspects of child development in terms of the value this information would yield toward education of the seriously emotionally disturbed child. Responses were recorded on a five point scale : Not at all important, of little importance, sometimes important, usually important and always important.

To accomplish the purpose of this study, the analyses described in Chapter III were tabulated to evaluate the responses of teachers, Chi square and Analysis of Variance were used to treat inferential data.

Question 1

Question 1 asked, To what degree do teachers of seriously emotionally disturbed children consider information about the physical, mental, psychological, social-emotional, and moral-ethical aspects of development relevant to his/her role in the the education of the child referred to the psychologist for evaluation? See table 2 for combined responses; table 3 for responses by individual state.

Chi Square analysis was used to determine whether or not responses of teachers in the seven states are equal in viewing the 5 categorical aspects of development contained on the psychoeducational developmental questionnaire.

Physical Data Summary

		*				
230	Data:	0	5	19	10	50
240	Data:	0	1	9	18	56
250	Data:	0	0	15	10	45
260	Data:	0	12	69	79	50
270	Data:	0	12	48	53	27
280	Data:	2	7	48	28	20
290	Data:	2	4	51	73	87

Chi Square is 155,116 Sig. at L.=.005

Psychological Data Summary

230	Data:	0	0	19	13	37
240	Data:	2	3	9	19	27
250	Data:	0	0	11	12	27
260	Data:	0	7	20	56	67
270	Data:	0	5	12	36	47
280	Data:	3	3	20	20	29
290	Data:	0	4	33	58	60

Chi Square is 47,3783 Sig. at L.=.005

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* col. 1=not at all important
col. 2=of little importance
col. 3=sometimes important
col. 4=usually important
col. 5=always important

Social-Emotional Data Summary

230	Data:	17	6	30	8	11
240	Data:	13	11	30	13	5
250	Data:	3	5	31	13	5
260	Data:	15	20	88	36	22
270	Data:	10	12	56	22	20
280	Data:	14	15	50	10	0
290	Data:	12	34	63	59	19

Chi Square is 76,2451 Sig. at L.=.005

Moral-Ethical Data Summary

230	Data:	14	3	19	6	18
240	Data:	5	12	12	16	5
250	Data:	6	0	22	10	12
260	Data:	14	27	39	33	37
270	Data:	8	16	27	21	28
280	Data:	3	3	37	18	14
290	Data:	11	33	61	42	8

Chi Square is 103,531 Sig. at L.=.005

Mental Data Summary

230	Data:	0	8	29	13	34
240	Data:	2	4	15	29	34
250	Data:	0	1	32	20	17
260	Data:	5	28	81	60	36
270	Data:	6	32	55	38	9
280	Data:	1	3	59	24	18
290	Data:	4	11	76	85	41

Chi Square is 136,155 Sig. at L.=.005

Findings: Summary results indicate $X^2 = 45.558$; Sig.at L.=.005
df= (7-1) (5-1)

There are differences at the .005 level of confidence in the categorical responses of the teachers in the seven states.

Question 2

Are the teachers' responses independent of the state in which they are employed?

ANOVA treatment of the data on mean responses of the one hundred thirty teachers in the seven states to the 30 item questionnaire resulted in the following:

```
300 Data: 332  312  302  307  367  361  363
310 Data: 381  412  371  398  387  396  367
320 Data: 428  420  419  410  393
330 Data: 238  252  327  293  292  217
340 Data: 379  353  314  173  183
                                   Total: 143,207
```

F. .05=2.76
F. .01=4.18

Are the mean responses for mental, physical,psychological, social-emotional and moral-ethical categories of items equal? No, they are different at the .01 level of significance.

Question 3

Does the teacher prefer a written report from the psychologist or does she/he prefer a written report combined with two-way communication, interpretation and discussion of the psychologists' findings?

One hundred percent of the teachers or one hundred thirty, in seven states preferred a followup conference with two-way communication and interpretation of the written report.

Instructions: Think of the child in terms of "an organic whole being" and the factors involved in the Thinking and Learning processes. MARK THE DEGREE OF IMPORTANCE OF EACH ITEM- as it relates to your need for information about the child, his education, and problems of learning.	Not at all Important	Of little Importance	Sometimes Important	Usually Important	Always Important
1. The intelligence quotient of the child.					
2. The results of prior testing.					
3. The educational implications of sub-test scores (WISC, WAIS, WPPSI).					
4. The clinical significance of sub-test scores.					
5. Survey of communication and information processing skills.					
6. Survey of problem solving skills.					
7. Reading comprehension and oral and written spelling ability.					
8. The nature of and limitations imposed by physical handicap.					
9. The medical diagnosis. The amount, kind and side effects of prescribed medication.					
10. The etiology of a child's speech problem.					
11. The measured degree of hearing loss and implications.					
12. The general physical health of the child.					
13. The degree of visual impairment.					
14. The laterality of the child and coordination.					
15. Overt aggressive behaviors: anger, destructiveness.					
16. Withdrawal symptoms: shyness, fear, phobia, depression.					
17. The child's reaction to male and female adult authority.					
18. The social maturity of the child. Cross problem solving.					
19. Social acceptance (peer group).					
20. Value judgments: Ethical and Moral sense.					
21. Anticipatory responses: foresight.					
22. The marital status of the parents or parent surrogate.					
23. The occupation of the parents.					
24. The birth order of the child.					
25. Sibling relationships in the home.					
26. The location and type of home dwelling.					
27. The number and relationship of people residing in the home.					
28. The race of the child.					
29. The church preference of mother and father.					
30. Does the child attend church services regularly?					

The combined responses of teachers in the seven states to the importance of each psychoeducational item is shown in Table 2. The degree of importance is calculated in percents determined from frequency counts: A categorical comparison (Table 2) yielded the following results listed in order of importance.

(1).Psychological = 3.18
(2).Physical = 2.91
(3).Mental = 2.57
(4).Moral-Ethical = 2.15
(5).Social-Emotional= 2.07

The items related to Psychological development was considered most frequently by teachers to be important to them in terms of information about the child who is severely emotionally disturbed. The category ranking second in importance, Physical development was followed closely by consideration of Mental development. While Moral-Ethical and Social-Emotional areas seemed to be of less importance in terms of the teachers' need for information, no category ranked unusually low or unusually high. Some inferences which might be made from the results viewed above could include: Teachers might feel that classroom observations of Social-Emotional behaviors was sufficient, or they might believe that their prime responsibility was to teach academic subjects and/or maintain discipline, teachers might support the theory that Moral-Ethical training belonged in the home training area. Teachers need to be cognizant of the need to understand the total child ; to improve weaknesses in any area.

Table 1

This table shows Questionnaire items in descriptive categories

Problems of Learning and Behavior

Instructions: Thinking in terms of the child as an "organic whole being" and the Physical-Mental-Social-Emotional-Moral and Ethical factors involved in the thinking and learning process---Please check your opinion on the degree of importance of each item---as it relates to your better understanding of the child --and his Educational Program and Problems of Learning

	Not at all Important	Of little Importance	Sometimes Important	Usually Important	Always Important	
1. The intelligence quotient of the child.						_ MENTAL
2. The results of prior testing.						_ MENTAL
3. The educational implications of sub-test scores (WISC, WAIS, WPPSI).						_ MENTAL
4. The clinical significance of sub-test scores.						_MENTAL
5. Survey of communication and information processing skills.						_ MENTAL
6. Survey of problem solving skills.						_MENTAL
7. Reading comprehension and oral and written spelling ability.						_MENTAL
8. The nature of and limitations imposed by physical handicap.						_PHYSICAL
9. The medical diagnosis. The amount, kind and side effects of prescribed medication.						_PHYSICAL
10. The etiology of a child's speech problem.						_PHYSICAL
11. The measured degree of hearing loss and implications.						_PHYSICAL
12. The general physical health of the child.						_PHYSICAL
13. The degree of visual impairment.						_PHYSICAL
14. The laterality of the child and coordination.						_PHYSICAL
15. Overt aggressive behaviors: anger, destructiveness.						_PSYCHOLOGICAL
16. Withdrawal symptoms: shyness, fear, phobia, depression.						_PSYCHOLOGICAL
17. The child's reaction to male and female adult authority.						_PSYCHOLOGICAL
18. The social maturity of the child. Cross problem solving.						_PSYCHOLOGICAL
19. Social acceptance (peer group).						_PSYCHOLOGICAL
20. Value judgments: Ethical and Moral sense.						_MORAL_ETHICAL
21. Anticipatory response: foresight.						_MORAL_ETHICAL
22. The marital status of the parents or parent surrogate.						_MORAL_ETHICAL
23. The occupation of the parents.						— SOCIAL_EMOTIONAL
24. The birth order of the child.						_SOCIAL_EMOTIONAL
25. Sibling relationships in the home.						_SOCIAL_EMOTIONAL
26. The location and type of home dwelling.						_SOCIAL_EMOTIONAL
27. The number and relationship of people residing in the home.						_SOCIAL_EMOTIONAL
28. The race of the child.						_SOCIAL_EMOTIONAL
29. The church preference of mother and father.						_MORAL_E HICAL
30. Does the child attend church services regularly?						_MORAL_ETHICAL

TABLE 2

** Combined Responses of Teachers in Seven States

Importance of each psychoeducational item:	* Not at all f.	%	* Of Little f.	%	* Some-times f.	%	* Usually f.	%	* Always f.	%
1. The intelligence quotient of the child	2	2	14	10	47	36	44	34	23	18
2. The results of prior testing	2	2	21	16	52	40	33	62	22	17
3. Educational implications of sub-tests (WISC,WAIS)	4	3	21	16	56	43	27	21	22	17
4. Clinical significance of sub tests (WISC, WAIS)	4	3	16	12	58	45	33	26	19	14
5. Survey of communic. and info. processing skills	0	0	4	3	50	39	41	31	35	27
6. Survey of Problem solving skills	2	2	5	4	46	35	44	34	33	25
7. Reading compreh;oral & written spelling skills	4	3	6	5	38	29	47	36	35	27
8. The nature and limitations of physical handicap	3	2	8	6	34	26	35	27	50	39
9. Medical diagnosis; side effects,dosage etc.	0	0	4	3	29	22	38	29	59	46
10. The etiology of the child's speech problem	1	1	7	5	39	30	46	35	37	29
11. Measured degree of hearing loss & implications	0	0	6	5	35	27	34	26	55	42
12. The general physical health of the child	0	0	2	2	13	10	47	36	41	32
13. The degree of visual impairment	0	0	4	3	37	28	38	29	51	40
14. The coordination and laterality of the child	0	0	10	8	45	35	33	25	42	32
15. Overt aggressive behaviors: anger, rage, destruct.	0	0	7	8	18	13	35	26	70	53
16. Withdrawl symptoms: fears, shyness, phobia,depres.	1	1	5	4	17	13	47	36	60	46
17. Child's reaction to male & female adult authority	1	1	4	3	18	13	49	38	58	45
18. Social maturity: Gross problem solving ability	1	1	3	2	25	19	47	36	54	42
19. Social acceptance by peer group	2	2	3	3	37	28	36	27	52	40
20. Value judgments: ethical and moral sense	2	2	8	6	31	24	47	36	42	32
21. Anticipatory response: foresight	1	1	9	7	49	37	38	28	37	27
22. Marital status of the parent or surrogate	8	6	15	12	47	36	35	27	25	19
23. Occupation of the Parents	19	15	23	18	58	44	21	16	9	7
24. Birth order of the child	12	9	27	22	59	45	21	16	11	8
25. Sibling relationships	3	2	9	7	53	41	48	37	17	13
26. The location and type of home dwelling	10	8	12	9	63	48	25	19	20	15
27. The no. and relationship of people in the home	3	2	18	14	69	53	24	19	16	12
28. The race of the child	37	28	14	11	46	36	21	16	12	9
29. The church preference of the parents	37	28	35	27	42	32	10	8	6	5
30. Does the child attend church regularly?	33	25	33	25	48	37	10	8	6	5

* f. = frequency of response

** Seven States : Delaware, Illinois, Iowa,
Maryland, New York, Pennsylvania
Wisconsin

Table 3

Responses of Teachers in Delaware

importance of each psychoeducational item:	not at all		of little		some- times		usu- ally		alw- ays	
** Item number:	*f.	%	*f.	%	*f.	%	*f.	%	*f.	%
1.	0	0	2	2	0	0	8	6	2	2
2.	0	0	0	0	3	2	4	3	5	4
3.	1	1	1	1	3	2	4	3	3	2
4.	1	1	0	0	4	3	6	5	1	1
5.	0	0	0	0	1	1	2	2	9	7
6.	0	0	1	1	1	1	3	2	7	5
7.	0	0	0	0	3	2	2	2	7	5
8.	0	0	0	0	1	1	2	2	9	7
9.	0	0	0	0	0	0	2	2	10	8
10.	0	0	0	0	1	1	5	4	6	5
11.	0	0	0	0	1	1	1	1	10	8
12.	0	0	0	0	1	1	4	3	7	5
13.	0	1	0	0	2	2	2	2	8	6
14.	0	0	1	1	3	2	2	2	6	5
15.	0	0	0	0	1	1	2	2	9	7
16.	1	1	2	2	2	2	7	5	2	2
17.	0	0	3	2	2	2	2	2	7	5
18.	0	0	1	1	2	2	5	4	5	3
19.	1	1	4	3	2	2	3	2	4	3
20.	1	1	1	1	1	1	5	4	2	2
21.	0	0	1	1	3	2	5	4	3	2
22.	2	2	4	3	2	2	4	3	0	0
23.	4	3	3	2	4	3	1	1	1	1
24.	0	0	4	3	4	3	3	2	1	1
25.	0	0	1	1	3	2	7	5	1	1
26.	2	2	1	1	7	5	1	1	1	1
27.	1	1	2	2	8	6	0	0	1	1
28.	6	5	0	0	4	3	1	1	0	0
29.	6	5	2	2	3	2	1	1	0	0
30.	6	5	2	2	3	2	1	1	0	0

* f. = frequency distribution

** item number = number corresponding to the item found on the psychoeducational instrument ie. 1. = Intelligence quotient of the child 2.= etc; refer back to page 46

Table 3 (continued)

Responses of Teachers in Wisconsin

Importance of each psychoeducational item : *	not at all		of little		sometimes		usually		always	
Item number :	f.	%	f.	%	f.	%	f.	%	f.	%
1.	0	0	0	0	4	3	6	5	5	4
2.	0	0	0	0	11	8	3	2	1	1
3.	0	0	1	1	11	8	2	2	1	1
4.	0	0	1	1	11	8	1	1	2	2
5.	0	0	1	1	9	7	2	2	3	2
6.	0	0	0	0	8	6	4	3	3	2
7.	1	1	0	0	5	4	6	5	3	2
8.	1	1	1	1	6	5	3	2	4	3
9.	0	0	2	2	5	4	3	2	5	4
10.	1	1	0	0	6	5	6	5	2	2
11.	0	0	1	1	7	5	6	5	1	1
12.	0	0	1	1	6	5	6	5	2	2
13.	0	0	2	2	5	4	9	7	4	3
14.	0	0	2	2	9	7	1	1	3	2
15.	0	0	2	2	3	2	4	3	6	5
16.	0	0	1	1	4	3	3	2	7	5
17.	1	1	0	0	3	2	4	3	7	5
18.	1	1	0	0	5	4	3	2	6	5
19.	1	1	0	0	5	4	6	5	3	2
20.	1	1	1	1	5	4	5	4	1	1
21.	1	1	2	2	2	6	5	4	1	1
22.	1	1	0	0	12	9	2	2	0	0
23.	2	2	5	4	8	6	0	0	0	0
24.	2	2	4	3	9	7	0	0	0	0
25.	1	1	1	1	10	8	3	2	0	0
26.	1	1	3	2	9	7	1	1	0	0
27.	1	1	2	1	9	7	3	2	0	0
28.	7	5	0	0	5	4	3	2	0	0
29.	6	5	2	1	7	5	0	0	0	0
30.	4	3	4	3	7	5	0	0	0	0

* For item description refer back to page 46

Table 3 (continued)

Responses of Teachers in Iowa

Importance of each psychoeducational item:	not at all f.	not at all %	of little f.	of little %	some-times f.	some-times %	usu-ally f.	usu-ally %	alw-ays f.	alw-ays %
* Item number:										
1.	0	0	5	4	14	11	8	6	3	2
2.	1	1	5	4	10	8	7	5	6	5
3.	1	1	7	5	10	8	7	5	5	4
4.	1	1	7	5	14	11	6	5	2	2
5.	0	0	1	5	15	12	9	7	5	4
6.	1	1	1	5	11	8	9	7	8	6
7.	1	1	1	1	7	5	14	11	7	5
8.	0	1	4	3	7	5	9	7	10	8
9.	0	0	0	0	9	7	13	10	8	6
10.	0	0	1	1	11	8	13	10	5	4
11.	0	0	1	1	10	8	11	8	8	6
12.	0	0	1	1	12	9	15	12	2	2
13.	0	[illegible]	2	2	10	8	10	8	8	6
14.	0	0	3	2	10	8	8	6	9	7
15.	0	0	2	2	3	2	12	9	13	10
16.	0	0	2	2	4	3	12	9	12	9
17.	0	0	2	2	3	2	11	8	14	11
18.	0	0	1	1	4	3	15	12	10	8
19.	0	0	0	0	6	5	6	5	18	14
20.	0	0	1	1	6	5	10	8	13	10
21.	0	0	2	2	10	8	8	6	10	8
22.	0	0	3	2	10	8	9	7	8	6
23.	4	3	2	2	17	13	4	3	3	2
24.	4	3	5	4	13	10	4	3	4	3
25.	0	0	1	1	14	11	11	8	4	3
26.	2	2	1	1	20	15	4	3	3	2
27.	0	0	5	4	15	12	7	5	3	2
28.	5	4	6	5	9	7	5	3	5	6
29.	7	5	13	10	4	3	3	2	3	2
30.	7	5	8	6	9	7	1	1	3	2

* For item description refer back to page 46

Table 3 (continued)

Responses of Teachers in Illinois

Importance of each psychoeducational item:	not at all		of little		some-times		usu-ally		alw-ays	
** item number:	*f.	%	*f.	%	*f.	%	*f.	%	*f.	%
1.	1	1	4	3	9	7	4	2	2	2
2.	1	1	8	6	8	6	3	2	0	0
3.	1	1	7	5	7	5	4	3	1	1
4.	1	1	6	5	8	6	3	2	2	2
5.	0	0	2	2	8	6	9	7	1	1
6.	1	1	1	1	9	7	8	6	1	1
7.	1	1	4	3	6	5	7	5	2	2
8.	0	0	3	2	8	6	5	4	3	3
9.	0	0	0	0	3	2	10	8	7	5
10.	0	0	2	2	6	5	8	6	4	3
11.	0	0	2	2	7	5	8	6	3	2
12.	0	0	0	0	9	7	8	6	3	2
13.	0	0	2	2	5	4	9	7	4	3
14.	0	0	3	2	10	8	5	4	2	2
15.	0	0	2	2	1	1	7	5	10	8
16.	0	0	2	2	0	0	9	7	9	7
17.	0	0	1	1	1	1	10	8	8	6
18.	0	0	0	0	0	0	5	4	15	12
19.	0	0	0	0	10	8	5	4	5	4
20.	0	0	0	0	2	2	8	6	10	8
21.	0	0	1	1	7	5	4	3	8	6
22.	0	0	1	1	7	5	5	4	7	5
23.	2	2	2	2	10	8	4	3	2	2
24.	2	2	2	2	12	9	1	1	3	2
25.	1	1	0	0	7	5	9	7	3	2
26.	1	1	2	2	10	8	3	2	4	3
27.	0	0	2	2	12	9	2	2	4	3
28.	4	3	4	3	5	4	3	1	4	3
29.	4	3	9	7	4	3	1	1	2	2
30.	4	3	5	3	7	5	3	1	1	1

*f.-= frequency of response

** item number = number corresponding to the item found on the psychoeducational instrument (page 46)

Table 3 (continued)

Responses of Teachers in New York

Importance of each psychoeducational item :	not at all		of little		sometimes		usually		always	
*	f.	%	f.	%	f.	%	f.	%	f.	%
Item number:										
1.	0	0	1	1	6	5	2	2	3	2
2.	0	0	6	5	4	3	0	0	2	0
3.	0	0	0	0	4	3	2	2	6	5
4.	0	0	0	0	4	3	2	2	6	5
5.	0	0	0	0	4	3	3	2	5	4
6.	0	0	1	1	3	2	2	2	6	5
7.	0	0	0	0	4	3	2	2	6	5
8.	0	0	0	0	3	2	2	2	7	5
9.	0	0	0	0	1	1	1	1	10	8
10.	0	0	4	3	3	2	1	1	4	3
11.	0	0	1	1	2	2	0	0	9	7
12.	0	0	0	0	3	2	0	0	9	7
13.	0	0	0	0	2	2	2	2	8	6
14.	0	0	0	0	5	4	4	3	3	2
15.	0	0	0	0	2	2	1	1	9	7
16.	0	0	0	0	1	1	0	0	11	8
17.	0	0	0	0	2	1	5	4	5	3
18.	0	0	0	0	3	2	5	4	4	3
19.	0	0	0	0	2	2	2	2	8	6
20.	0	0	0	0	2	2	2	2	8	6
21.	0	0	0	0	5	4	0	0	7	5
22.	4	3	2	2	1	1	3	2	2	2
23.	5	4	1	1	4	3	0	0	2	2
24.	2	2	2	2	6	5	2	2	0	0
26.	2	2	0	0	4	3	1	1	5	4
27.	0	0	1	1	8	6	3	2	0	0
28.	7	5	0	0	3	2	1	1	1	1
29.	6	5	0	0	5	3	1	1	0	0
30.	4	3	1	1	6	5	0	0	1	1

* For item description refer back to page 46

Table 3 (continued)

Responses of Teachers in Pennsylvania

Importance of each psychoeducational item: * Item number:	not at all f.	not at all %	of little f.	of little %	some-times f.	some-times %	usu-ally f.	usu-ally %	alw-ays f.	alw-ays %
1.	1	1	1	1	10	8	15	12	4	3
2.	0	0	0	0	11	8	3	2	1	1
3.	1	1	5	4	13	10	7	5	5	4
4.	1	1	2	2	12	9	11	8	5	5
5.	0	0	0	0	10	8	12	9	9	7
6.	0	0	1	1	11	8	14	11	5	4
7.	1	1	1	1	10	8	12	9	7	5
8.	2	2	0	0	7	5	11	8	11	8
9.	0	0	2	2	8	6	8	6	13	10
10	0	0	0	0	10	8	11	8	10	8
11	0	0	1	1	6	5	8	6	16	12
12.	0	0	0	0	7	5	12	9	12	9
13.	0	0	0	0	7	5	11	8	13	10
14..	0	0	1	1	6	5	12	9	12	9
15.	0	0	1	1	6	5	7	5	17	13
16.	0	0	0	0	4	3	13	10	14	11
17.	0	0	0	0	6	5	14	11	11	8
18.	0	0	2	2	8	6	12	9	9	7
19.	0	0	1	1	9	7	12	9	9	7
20.	0	0	3	2	12	9	14	11	2	2
21.	0	0	3	2	14	11	14	11	0	0
22.	1	1	5	4	12	9	9	7	4	3
23.	2	2	9	7	10	8	9	7	1	1
24.	2	2	9	7	9	7	9	7	2	2
25.	0	0	3	2	10	8	14	11	4	4
26.	2	2	4	3	9	7	12	9	5	4
27.	1	1	5	4	11	8	8	6	6	5
28.	5	4	4	3	14	11	7	5	1	1
29.	5	4	9	7	13	10	3	2	1	1
30.	5	4	13	10	10	8	2	2	1	1

* For item description refer back to page 46.

Table 3 (continued)

Responses of Teachers in Maryland

Importance of each psychoeducational item:	not at all		of little		sometimes		usually		always	
	f.	%	f.	%	f.	%	f.	%	f.	%
* Item number:										
1.	0	0	1	1	4	3	1	1	4	3
2.	0	0	0	0	6	5	2	2	2	2
3.	0	0	0	0	8	6	1	1	1	1
4.	0	0	0	0	5	4	4	3	1	1
5.	0	0	0	0	3	2	4	3	3	2
6.	0	0	0	0	3	2	4	3	3	2
7.	0	0	0	0	3	2	4	3	3	2
8.	0	0	0	0	2	2	3	2	5	4
9.	0	0	0	0	3	2	1	1	6	5
10.	0	0	0	0	2	2	2	2	6	5
11.	0	0	0	0	2	2	0	0	8	6
12.	0	0	0	0	2	2	2	2	6	5
13.	0	0	0	0	2	2	1	1	7	5
14.	0	0	0	0	2	2	1	1	7	5
15.	0	0	0	0	2	2	2	2	6	5
16.	0	0	0	0	2	2	3	2	5	4
17.	0	0	0	0	1	1	3	2	6	5
18.	0	0	0	0	3	2	5	4	4	3
19.	0	0	0	0	3	2	2	2	5	4
20.	0	0	0	0	3	2	3	2	4	3
21.	0	0	0	0	4	3	2	2	4	3
22.	0	0	0	0	3	2	3	2	4	3
2[illegible].	0	0	1	1	5	4	3	2	1	1
2[illegible].	0	0	1	1	6	5	2	2	1	1
2[illegible].	0	0	1	1	4	3	3	2	2	2
26.	0	0	1	1	4	3	3	2	2	2
27.	0	0	1	1	6	5	1	1	2	2
28.	3	2	0	0	6	5	1	1	0	0
29.	3	2	0	0	6	5	1	1	0	0
30.	3	2	0	0	6	5	1	1	0	0

* For item description refer back to page 46

Scope of the Study

Limitations

Only teachers who were directly involved in classroom settings where emotionally disturbed children were in attendance were included in the study.

To accomplish the purpose of this study, the investigation was confined to the analysis of data on teacher responses to the questionnaire and the psychoeducational instrument.

These teachers, however, represent a unique sample of the total population of public, private, and clinic school teachers in respect to their teaching commitment. Theirs is a dual role of Academic and Socialization education.

Their responses represent the thinking of a mature, experienced element of the total teacher population; they needed the skills to teach academic subjects as well as the physical stamina to tolerate and attempt to modify the kinds of maladaptive behaviors frequently found among their students.

The daily planning and the adaptation of curriculum materials required to meet individualized instructional needs of students while implementing techniques of behavior modification in order to make instruction possible is a complex task. It requires an individual with the ability to adapt and adjust to change in routine that may be immediate. Teaching emotionally disturbed children presents a constant challenge.

In viewing Table 2 in terms of individual items, numbers 28, 29, and 30 were considered of low importance to many teachers; however a higher percentage believed them to be sometimes important. Individual items of high value were numbers 15, 16, and 17; number 9 also was viewed to be of high importance.

Table 3, composed of seven sections, one for each state included in the study, shows how each state responded individually to the thirty items on the psychoeducational questionnaire.

Wisconsin teachers tended to select the "Sometimes" degree of importance more frequently than "Not at all," or "Always" degree of importance; Iowa teachers rated the Psychological and Social-Emotional items with a high degree of importance, as did Illinois teachers. New York respondents maintained a relatively close balance between mental, physical, and psychological choices while Pennsylvania's greatest number of high selections were in the physical and psychological areas. Maryland teachers tended to present a categorical balance in the "Sometimes," degree of importance, with the exception of high selection in the area of physical development. Delaware teachers chose most items in the mental, physical and psychological areas as being highly important.

Since no expectations or predictions had been made about teacher responses prior to the administration of the data collecting instruments, the information gained from this Library research/Fact finding study was considered to be pure in form.

Summary

The results of this study indicate that the teachers of seriously emotionally disturbed children (n.=130) from the states of Delaware, Illinois, Iowa, Maryland, New York, Pennsylvania and Wisconsin did view the child as an organic developing total organism when responding to the psychoeducational questionnaire.

Statistical treatment of the data revealed statistical differences in mean responses at the .01 level of significance in mean responses for the mental, physical, psychological, social-emotional and moral-ethical aspects of development. Chi square analysis of item analysis revealed significant differences at the .005 level.

Tables 2 and 3 give the reader the opportunity for a "closer look" at specific items considered by teachers in the various states.

Tables 3a and 3b may be viewed in terms of reader interest; no teacher in the random samples had less than 7 years of teaching experience and the degrees held ranged from B.A. to Ed.S.

Table 3 (a)

Teacher Training and Experience by Geographical Area

Area	Location	*No. T.	Random Sample	%Total (in-State)	Education BA	MA	Ed.S.	Ave. Experience/Yrs. Public-	Priv.-	Clinic
NE	Delaware	12	5	42	1	4	0	10	2	4
MW	Illinois	20	5	25	2	2	1	11	0	1
MW	Iowa	30	5	17	1	4	0	10	4	6
NE	Maryland	15	5	33	0	5	0	10	4	1
NE	Pennsylv.	31	5	16	2	3	0	6	1	5
NE	New York	12	5	42	2	3	0	4	7	1
MW	Wisconsin	20	5	25	2	3	0	7	7	1

Table 3 (b)

Area	Location	Ave. Age:T.	Random Sample	% Total Area N.= 65	Ave. Exp. related areas: camp, counseling, hosp., bus driver, soc.wk. (yrs.)
NE	Delaware	42	5	8	3
MW	Illinois	37	5	8	4
MW	Iowa	43	5	8	4
NE	Maryland	45	5	8	2
NE	Pennsylv.	33	5	8	1
NE	New York	34	5	8	1
MW	Wisconsin	38	5	8	2

* T= Teachers

Teachers tended to omit the blank intended to collect information on the size of the district in which they were employed; information obtained was insufficient for reporting.

Random samples of Northeastern and Middlewestern teachers found in the Appendix section (see table of contents) reveal both interesting and informative statements and comments about their work with children who are emotionally disturbed.

One hundred percent of the teachers responding, preferred a written report with two-way communication about the results, to a written report without personal follow-up.

CHAPTER V

SUMMARY AND CONCLUSIONS

The major thrust of this study was to determine which elements of psychoeducational evaluation are seen by teachers as most helpful in working with emotionally disturbed children. Additional information was saught regarding teacher background in terms of preparation and experience. In depth investigation of the developmental processes involved in personality formation was made which included causal factors in the formation of disturbed personality.

In mental illness, abnormality is in the mind, the emotions and overall behavior. Three basic types of abnormal behavior may be viewed: unrealistic, irrational and inappropriate. Since the great majority of mental illnesses are believed to have a predominantly psychological cause, the role of the psychologist in the diagnostic care and treatment program can be vital to teachers and other team members.

Since the formation of emotional disorders is complex and involves the whole person, the diagnosis becomes complex and should involve the whole person. For example, stressful emotional experiences in childhood that warp or change the emotional response cause the individual to behave abnormally.

Some individuals may have a constitutional deficit or weakness; parental rejection or extreme punishment may produce reactions on the digestive system and internal organs. The stronger the emotional response, the more powerful the visceral reactions; the longer the emotion is sustained the greater the visceral (machinery of emotions) reaction. For example in a neurosis, the state, rage, grief etc. continues. When this happens, malfunctioning or injury to the organs occur resulting in chronic indigestion, hypertension, heart trouble or other physical illnesses which are not imaginary, and do require medical attention as well as mental health treatment. Personality disorders are evident in all children accepted for treatment; classified as suffering from convulsive disorder, brain syndromes, manic depressive reaction, schizophrenic reaction, psychoneurotic reaction and a range of other disorders.

Emotional problems are a prime contributor to the development of a wide variety of learning disorders in children causing the role of the classroom teacher to be an extremely important one.

The results of this study revealed that the greatest number of teachers considered the Psychological and Physical aspects of development to be most important in terms of need for information relevant to the teaching role; Moral-Ethical and Social-Emotional Aspects of lesser importance.

A random sample of 5 teachers from each was taken from the Teacher Training and Experience Questionnaire (see Table 3 a,b) and their responses revealed that 24 teachers of the 35 in the random sample held Master Degrees, 1 an Education Specialist Degree and 10 held Bachelor Degrees in the Arts or Science. The average number of years of teaching experience in public school was 8 years; in private school 3.6 and in a clinic setting, 2.7, in the random sample of 35 teachers from the 7 states included in the study. The average age of these teachers was 39 years, and the average years of working with handicapped children in areas other than classroom was 2.4.

The teachers in the random sample were mature in age, held advanced degrees in most settings, and had served handicapped children in some capacity other than teaching.

The results of responses of these teachers (random sample) may be seen in Appendix F, and are deserving of comment in terms of their implications. Some exerpts are as follows:

1. Many of these kids are rough, impulsive and sometimes dangerous; it is not a job for the "faint heart".
2. Give the children a reason to feel "worthwhile"; they have suffered much personality damage.
3. Social problems are so severe that academic work usually seems secondary.
4. They do not respond to the normal control methods usually employed in a public school.
5. Without medication, some of these children could not be contained in a group situation.
6. Give encouragement and praise, even for small improvements.
7. The "total child approach" can best be applied in a clinic or residential setting.
8. They need help and I want to help them but it's very, very discouraging.
9. Let them know that you are the authority, but be reasonable.
10. Individualize materials; relate to the child's needs.

Teacher comments about these children may reflect their concerns.

As indicated in Chapter IV, teachers seemed to be cognizant of individual developmental differences when responding to items on the Psychoeducational Questionnaire. Results indicated that there was a significant difference in the way in which they viewed the importance of the items in terms of a personal need for information.

Implications

Some implications based on the findings of this study include:

1. Working with children who are seriously emotionally disturbed is strenuous; requires patience, tolerance and fortitude on the part of the teacher.
2. The process of habilitation or rehabilitation is slow and often spasmodic.
3. Medication is sometimes an absolute necessity for behavior control acceptable in the classroom
4. A positive approach should be maintained whenever possible to aid the child in building a positive self-image.
5. Structure is vital; firm discipline is necessary.
6. A maladjusted child often displays symptoms of a disorder in more than one developmental area.
7. Well trained and experienced teachers need constant reinforcement and communication with other team members in order to maintain a positive attitude toward working with disturbed children.
8. School districts and Teacher Training Institutions may need to provide more realistic programs for teachers preparing to work with these children.
9. Residential treatment gains made by the children may be lost if adequate follow-up is not provided.

10. Families of these children need to be involved in the treatment program; in the absence of natural parents, surrogates must assume responsibility for the welfare of the children.

11. Treatment should begin at as early an age as possible if satisfactory long term results are to be realized.

12. The numbers of children requiring treatment has increased steadily during the past two decades.

13. Services from the various states are increasing in an attempt to meet the needs of this increasing population

14. The basic needs of emotionally disturbed children are the same as other children: love and affection, a feeling of self worth, a feeling of belonging, adequate food, shelter, clothing and general health care.

15. If properly treated, the conditions of emotional disturbance may be removed, and the individual may be able to live a very useful and productive life.

Further implications of this study indicate that the psychologist can provide for the teacher of the seriously emotionally disturbed children, that information which the teacher has specifically pinpointed. The selection of a battery of appropriate tests when needed, combined with various other psychoeducational techniques has refined the diagnostic process. The time saved in unnecessary testing can be more effectively utilized by discussion of the findings with the teacher, interpreting, and when necessary, explaining how the findings can be interpreted in terms of value. Psychologists have identified for the teacher strengths and weaknesses and can assist in the selection of appropriate materials to individualize instruction and aid in developing programs of behavior modification. It is of vital importance that the psychologist follow up his/her recommendations and aid the teacher in a supportive manner.

The Written Report

In writing the report, the psychologist should bear in mind that the tests must be viewed in relation to the individual psychopathological problem which needs to be treated. Although a psychoeducational evaluation may be considered cross-sectional in nature, no more testing should be done than is necessary to answer the particular problem to be solved. The terminology of the report should allow for easy communication. It was the basic contention of Klopfer (1959) that any statement found in a psychological report could be made comprehensible to any literate individual of average intelligence, for example: hostility toward the father figure, might be written, the child is so fearful and suspicious of people in authority that he automatically assumes an aggressive attitude toward them.

Suggestions for Further Research

Research in the field of serious emotional disturbance presents a particular challenge since each person is unique, each disorder, while carrying a familiar label, is inherent in an individual whose body chemistry and encompassing environment is unique.

However, some possibilities for research which would allow for better understanding of this complex condition might include:

a. A thorough investigation of existening training programs with a focus on finding out what treatment methods or behavior modification techniques really bring about changes which allows classroom participation in the immediate setting and which offer elements for development of internalized control for the child.

b. Followup programs designed for individual children who have received residential treatment and have been returned to Special or regular classrooms in the Community might be investigated.

c. Experimental diagnostic methods may be utilized to attempt to determine appropriate ways to detect major strengths and weaknesses in different types of children.

d. Comparison of different Teacher personality types with like or different personality development tendencies in children.

e. Further investigation of conditions that produce maladjustment might add to existing knowledge and produce evidence confirming the need for change.

f. Investigation of training programs currently being held for foster parents, surrogate siblings and child advocates.

g. Comprehensive interviews and contacts directly with the children may allow further insight into the way the children view themselves and their difficulties.

Psychology is a profession of change, and its practitioners must be sensitive to the interrelationship between the various disciplines of investigation and diagnosis. The fields of medicine, anthropology, sociology, education, religion, philosophy offer resources for the psychologist to obtain necessary insights for accurate diagnosis. Law and political change, public opinion, public programs, private options, controversial population questions, and a highly mobilized society contribute to the vitality and promise of psychological investigation to aid the cause of severe emotional disturbance.

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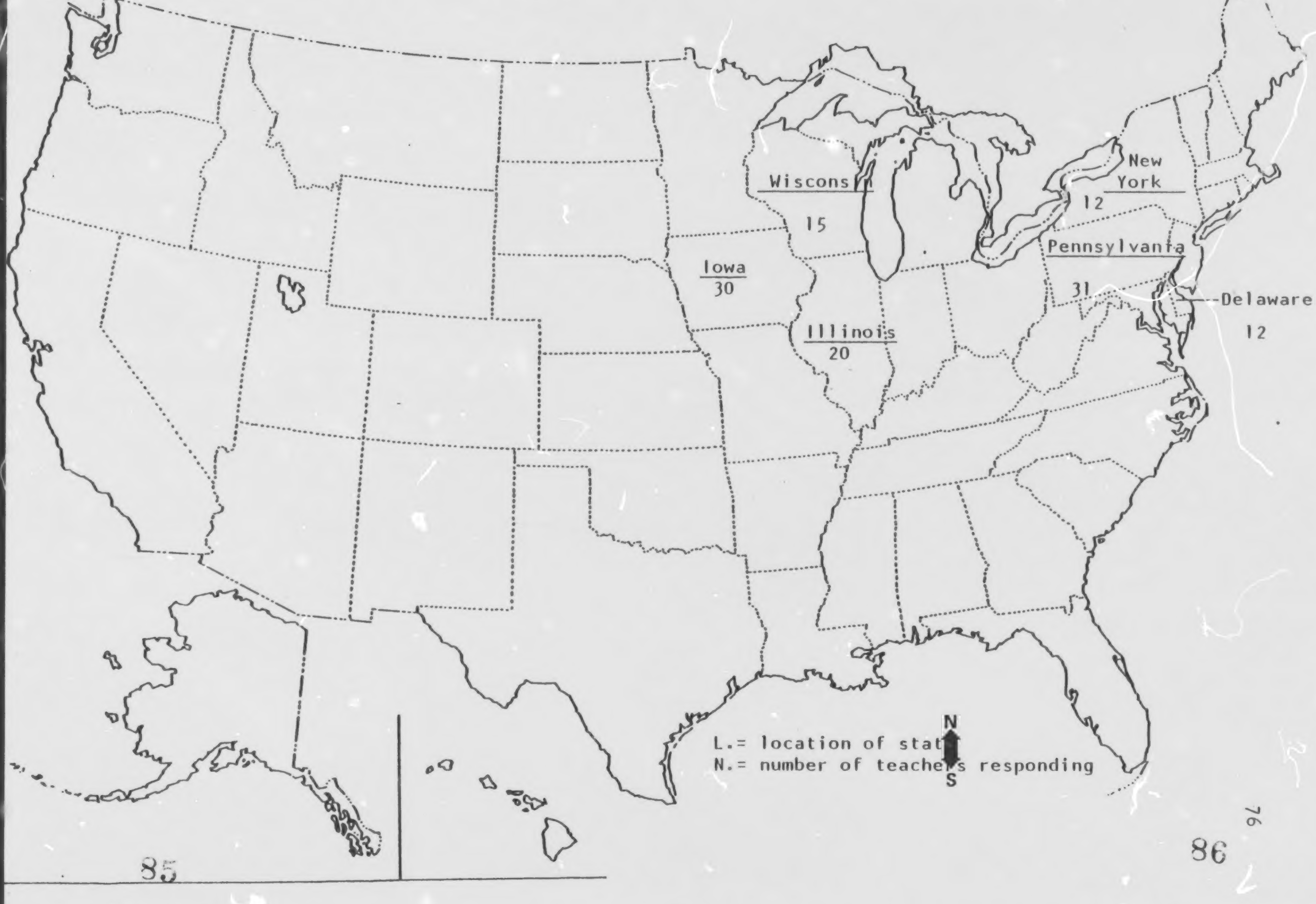
APPENDIX A


Wisconsin
15
Iowa
30
Illinois
20
New York
12
Pennsylvania
31
Delaware
12
L.= location of state
N.= number of teachers responding
N
S

Instructions: Think of the child in terms of "an organic whole being" and the factors involved in the Thinking and Learning processes. MARK THE DEGREE OF IMPORTANCE OF EACH ITEM- as it relates to your need for information about the child, his education, and problems of learning.	Not at all Important	Of little Importance	Sometimes Important	Usually Important	Always Important
1. The intelligence quotient of the child.					
2. The results of prior testing.					
3. The educational implications of sub-test scores (WISC, WAIS, WPPSI).					
4. The clinical significance of sub-test scores.					
5. Survey of communication and information processing skills.					
6. Survey of problem solving skills.					
7. Reading comprehension and oral and written spelling ability.					
8. The nature of and limitations imposed by physical handicap.					
9. The medical diagnosis. The amount, kind and side effects of prescribed medication.					
10. The etiology of a child's speech problem.					
11. The measured degree of hearing loss and implications.					
12. The general physical health of the child.					
13. The degree of visual impairment.					
14. The laterality of the child and coordination.					
15. Overt aggressive behaviors: anger, destructiveness.					
16. Withdrawal symptoms: shyness, fear, phobia, depression.					
17. The child's reaction to male and female adult authority.					
18. The social maturity of the child. Gross problem solving.					
19. Social acceptance (peer group).					
20. Value judgments: Ethical and Moral sense.					
21. Anticipatory response: foresight.					
22. The marital status of the parents or parent surrogate.					
23. The occupation of the parents.					
24. The birth order of the child.					
25. Sibling relationships in the home.					
26. The location and type of home dwelling.					
27. The number and relationship of people residing in the home.					
28. The race of the child.					
29. The church preference of mother and father.					
30. Does the child attend church services regularly?					

Name:______________________Age___Sex____Degree_________

Address____________________System____________Size______

Years of experience in a Public School System__________

Years of experience in a Private School System_________

Years of experience in a Clinic ________________________

Major training Centers _________________________________

Other experience related to care and treatment of handicapped children____________________________________

____

List ideas,(personal)feelings, or recommendations you may have about working with children with emotional problems.

1.____

____

____

____

2.____

____

____

3. Give your personal opinion about the kind of report you would like to receive from the psychologist:

    a) a written report with recommendations

    b) a written report combined with two-way communication of results obtained -

4.____

APPENDIX B

What are the psychological and philosophical bases of residential treatment of children who are emotionally disturbed?

Until the last two or three decades, institutionalized patients were provided with kind and thoughtful custodial care at best, and at worst were incarcerated in filthy wards, tied down, crammed together and isolated from the interests of the larger community. Deutsch (1948) reported in his book, The Shame of the States, that most hospital patients in the mid-twentieth century sat out their lives in dreary environments.

The change from inhumane to custodial to genuine therapeutic environments care about through the development of psychopharmacological treatment. These "drugs" contained difficult patients, allowing hospital workers to turn attention from problems of "restraint " to those of therapy. The transformation was not rapid, since hospital attendants were accustomed to viewing their patients from a hopeless frame of reference.

The well operated mental treatment center is a "therapeutic treatment center." It is a miniature environment which stimulates activities of the outside world; it differs from a "true society" only in that it is designed to assist residents to learn to replace maladaptive and deficient behaviors with more appropriate ones.

Before the advent of Children's Units, mentally ill children were housed in the same buildings with adult and adolescent patients. The movement toward the establishment of separate treatment units was prompted by the increased numbers of children needing this service. Public awareness was brought about through the publications of Strauss and Lehtinen (1950) , Cruickshank (1965) , Kephart (1960), Birch (1964) , Rappaport (1966). Recognition of some etiological differences between brain injured and "emotionally disturbed" was established.

The etiology of an emotionally disturbed personality involves the investigation of complex interaction between a developing organism and its' encompassing environment. Children from deprived homes, broken homes, those with poor mental or physical capacities, and others whose development was void of parental love and security are especially vulnerable to environmental stress. When the stress becomes greater than the individual can tolerate, some form of maladaptive behavior results. It is well to remember that there is no separation, but rather continuous interaction between intelligence, emotion, social influences and biological change in the development of personality of any individual.

Admissions to the hospital generally come from the city or the County Commission for Hospitalization, by voluntary admission, or by service request from Juvenile Court Order. The seriousness of the condition warrants full service to patients including: Psychiatric and Psychological service, Medical Laboratory service X-Ray, EEG, Nursing service, Social Services, Pastoral, Cosmetology, Recreation, Therapy, Education, Vocational Education, and Dietary service.

How then, does the hospital staff utilize these extensive services to accomplish a major goal of assisting residents to learn to replace maladaptive and deficient behaviors with more appropriate ones?

1. The first is the simple act of removing the patient from normal environmental stresses and placing him in a quiet and tolerant setting. Here, he/she will be "safe" from external environmental sources which may have produced the existing condition. In this environment feelings may be released without condemnation, and as the patient's anxieties are reduced, a measure of calm and composure may be realized.

2. The achievement of the first goal prepares the patient for the second and more important: therapy; developing increased social competence. Every facet of the in-patient routine life including housekeeping and recreation becomes a therapeutic experience.

    2.1 Therapy goals include: increasing competence
    occupational rehabilitation
    group planning activities

    2.2 Milieu therapy techniques may include:
    Biophysical therapy- used by those trained in psychiatric medicine; may employ drug chemical or surgical treatment
    Intra-psychic therapy- used by those who employ techniques to release repressed conflicts from the unconscious (free association-dream analysis)
    Behavioral therapy - used by those who concern themselves with overt action: focus on deficient behaviors

2.2 (continued)
Educational Therapy- Special Education techniques and methods allowing for stress reduction
Vocational Therapy- improved skills; learning new skills
Electroconvulsive Therapy - used by specialists to induce convulsive therapy
Focul stimulation - used by specialists to stimulate the neural system

3. Psychological approaches to treatment

3.1 individual patient therapy (one-one)
3.2 small group therapy (interplay among patients and unfolding of social attitudes and interpersonal styles of behavior
3.3 institutional milieu - "total program effort" physical, recreation, ward, cafeteria.

4. Social case work

4.1 assists the child and family or caretaker while the child is hospitalized
4.2 followup service (home or other release institution

5. Supportive therapy

5.1 helps the patient manage his/her environment
5.2 helps borderline personalities become stable
5.3 patients who are a threat to self or others
5.4 helps implement stability in very insecure patients

The patient is treated in the confinement center for residential care until such time as strong evidence supports the belief that his/her response to treatment has been satisfactory and release papers are signed. Followup plans are written and supreme effort is made to assist those who will be concerned about the released person in the society at large.

Identify and contrast the issues and approaches involved in institutional vs foster home care of emotionally disturbed children.

Institutional care: Care provided in a confinement setting for severe emotional disturbance and/or mental impairments in which a child is judged to be incapable of assuming responsibility for his/her actions.

Confinement of an individual for the purpose of psychotherapy treatment is not a new concept; psychotherapy has a long history as treatment by this method was first proposed by Johannes Reil in 1803. Psychological treatment was first recorded in the temple practices of Greeks and Egyptians in the eighth century B.C. In Egyptian "hospices" physician-priests interpreted dreams and suggested solutions to earthly and heavenly problems. In Greek temples, located in regions remote from sources of stress, the ill were provided with herbs, rest, massage and soothing music.

During the 5th. Century B.C. Hippocrates suggested exercise and tranquility to replace practices of exorcism and punishment. Asclepiades, a Roman in the first century B.C/ devised measures to relax patients and openly condemned "therapeutic methods" of blood letting and mechanical restraints. (Millon), Soranus (120)A.D, suggested exercises to enrich the mind. He denounced then, the common practices of keeping patients in darkness and depleting their strength by fasting and bleeding.

In medieval times, humane treatment of the mentally ill was totally abandoned when witchcraft and other cruel, regressive acts were employed as therapy. Institutions were prevalent, but served as places to incarcerate and isolate, rather than to provide medical and human care.

The next phase of psychological treatment may be termed, "the period of hospital reformation ans moral treatment pioneered by Philippe following the French Revolution. (early 1800's). His approach penetrated tradition, but failed to take root for many years. There was a resurgance from the mid-nineteenth to early twentieth century of the medical disease model.

In the United States, the pattern of institutional care did not change dramatically until the late 1950's (Rogers and Dymond, 1954; Hunt, 1952) Eysenck (1952), Zubin (1953) utilizing and critically examining psychotherapy methods.

Services typically offered in State Hospitals in the 1970's include:

a. admission unit
b. continued treatment units
c. long term care nursing service
d. court study unit
e. adolescent unit
f. day and night treatment center
g. geriatric treatment center
h. alcoholic treatment

The overall moral reform of the "total" hospital concept created a division of services to children and adolescents formerly housed in the same buildings with adults.

The philosophy of treating children at an early stage of disability is currently believed to be a "preventative approach" to development of stable habit formations which produce deviant behaviors. In some cases the habilitation and/or rehabilitation process is completed in a relatively short (three months) period of confinement; in severe cases, a longer extention is required to meet the individual needs of the child or adolescent. The services required may include but not be limited to:

a. medical treatment
b. nursing care
c. psychotherapy
d. group therapy
e. milieu therapy
f. occupational and vocational therapy / workshops
g. educational service and other treatment services as needed

Few individuals respond to some form of treatment and frequently the results of in-patient service are immediate and highly rewarding; however in the majority of cases, the difficulty causing admission requires a lengthy and complex series of sequentially designed steps to recovery. The question then arises regarding the long range plan for the renewed inpatient. Will the "changed individual" be able to retain benefits derived from care and treatment when s(he) again is confronted with some of the same environmental presses which aided in creating the original problem?

It is believed by institutional supporters, that the person considered to be eligible for release will have been sufficiently conditioned to withstand external environmental pressures with the aid of follow-up support appropriate to a given condition.

Special consideration must be given to the orphan child, the child from a broken home with a mother as head of the household, the one-parent home with the father as head of the household, the child with one or both parents imprisoned, the abused child, the abandoned child, the child whose parents are deceased. Should these children be retained for indefinite, long term residential care in the treatment institution or transferred to another institutional setting or placed in foster care in a home?

Despite the advantages offered by the institutional setting during the period of intensive treatment, many proponents of "foster home care" believe that a vital element of naturalistic living in terms of normal growth and development is missing.

Pearl Buck, in Children for Adoption, stated that, "The community must take the place of the large family unit; the community must assume responsibility for each child within its' confines." She believes that more effort and funding should be geared toward a preventative approach to emotional illness in children by focus on a weak, unstable family structure which fosters the disturbance.

Home aid in some cases could be provided at minimal cost, foster home care requires a higher rate, institutional care a still higher rate but when a child becomes so seriously disturbed that residential psychiatric care is needed, the cost can become exceedingly great.

In Buck's study of 100 emotionally disturbed children, all homes except one had disturbed famililies. Forty eight were so severely disturbed that they could not form new family ties. Emotional disturbance had increased markedly since separation from their parents. Encyclopedia Americana as a source of reference stated that the marked increase in numbers of children in need of foster home care or adoption following World War II increased still more in the 60's. Education is drastically needed in how to cope with the increasing problems related to adjustment. Geiser (1973), in The Illusion of Caring," writes: "Theoretically, foster care was conceived as a short-term placement, a way station on the road to adoption. In practice, nothing could be further from the truth." Adoption is a realistic possibility for an extremely small number of children in foster care under public auspices were receiving adoption services, and many of them will not be adopted due to: laws which vary from state to state, in some cases the requirement of parental concent, interracial adoptions and adoptions of children with handicapping conditions. Private care for children provided by church groups, charitable societies, and individuals are valiently making an attempt to supplement public welfare aid as there is a general axiom that no child under six years of age should be placed in an institution.

The debate about which kind of care is best, foster home care o institutional care continues, but has been temporarily resolved in favor of foster home care. In reality, both kinds of care are needed. The institution may be best for adolescents trying to away from parents, aggressive, acting out, violemt children and those who have failed several foster home placements. Probably many of the decisions in child welfare are based firmly upon cherished ideals, beliefs and fantasies but are not rooted in facts.

APPENDIX C

Standards for Special Education, Department of Education, Commonwealth of Pennsylvania-Annex a (22 Pa. - Code CH - 341)

Definition:

(p.3)

7.) Severely Multihandicapped Persons who are diagnosed as having two or more of the following severe handicapping conditions required for assignment to approved private schools(22 Pa. Code 171.23 F)

v. Emotional Disturbance: Those persons who manifest severe major affective psychoses which is characterized by a single disorder of mood, either extreme elation or depression that dominates the mental life of the person and is responsible for whatever loss of contact they may have with their environment.

8.) Socially and Emotionally Disturbed : A condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree: an inability to learn which cannot be explained by intellectual, sensory or health factors; an inability to build or maintain satisfactory interpersonal relationships with peers and teachers; inappropriate types of behavior or feelings; a general pervasive mood of unhappiness or depression; or a tendency to develop physical symptoms, pains or fears associated with personal or school problems. A person shall be assigned to a program for the socially and emotionally disturbed when the evaluation and the individualized program of Education indicate that such a program is appropriate, provided that the evaluation includes reports from a board certified or approved psychiatrist.

No person shall be assigned to a program for the socially and emotionally disturbed for disciplinary reasons alone. Socially and emotionally disturbed children shall be psychiatrically reevaluated every two years.

Rules and Regulations to Govern the Administration and Operation of Special Education. State Board of Education: Illinois

ARTICLE II
2.04
The local school district shall be responsible for ensuring that those children who require special education services enjoy the rights and privileges equal to those of all other children.

1. No exceptional child between the ages of three and twenty-one may be permanently excluded from the public schools either by direc direct action of the board of education, by indication of the district's inability to provide an educational program, or by informal agreement between parents and the school district to allow the child to remain without an education program.

ARTICLE III
3.01
Each local school district shall establish and maintain special education instructional programs, resource programs, and related services which meet the educational needs of children with the following exceptional characteristics:

e. Educational maladjustment related to social or cultural circumstances

f. Affective disorders or adaptive behavior which restricts effective functioning

ARTICLE IX
9.16

7.Behavior disorder- The child exhibits an affective disorder/and or adaptive behavior which significantly interferes with his or her learning/and/or social functioning. (14-1.05 of the School Code of Illinois)

9.Multiple impairment- The child exhibits two or more impairments, severe in nature and total impact, which significantly affect his or her ability to benefit from an educational program. (14-1.07 or the School Code of Illinois)

ARTICLE VIII
8.01
If a child exhibits exceptional characterissics which are determined in a multidisciplinary conference to be so profound, complex, or otherwise unique that no special education program offered by the public schools can adequately or appropriately meet his or her needs, the student shall be referred for placement in either a state operated or a private facility.

ARTICLE XV
1501
15.02
The purpose of Section 14-7.03 of The School Code of Illinois shall be considered to be to assure equal acc access to educational opportunity for exceptional children living in residential care facilities. The following shall be included: Orphanage, Foster Family Home, State Residential Units.

ARTICLE XI
11.01
The concept of surrogate parents will be implemented by guaranteeing procedural safeguards to children who are wards of the state pursuant to the provision of the Juvenile Court Act. (Ill. revised statutes, Ch.37,Sec,701)

Authorization for special programs and definitions of the condition of emotional disturbance in the seven states included in the study are the following:

Administrative Manual for Programs for Exceptional Children, (Revised), 1978 , pp 21-22. Department of Public Instruction, Dover, Delaware.

Programs may be provided for exceptional children who are between the ages of 4 and 21 (9310),Title 14) and of hearing or visually impaired, between the ages of 0 and 21.

Criteria for eligibility or definition:

6.)Social or emotional maladjustment

The child who exhibits behavior representative of conflict between self and environment repeatedly and over time to such an extent and duration that it significantly impairs the learning process.

a.) Acting out behavior such as unpredicted and unprovoked hitting, aggressive and disruptive behaviors.

b.) Withdrawing behavior such as absence of speech, depression, impulsive and obsessive behaviors.

c.) Defensive behaviors such as compulsive eating, manipulating or running away from home or school.

d.) Disorganized behaviors such as out-of-touch with reality, self-abusive behavior, lack of self control as determined by a Psychiatrist or Psychologist.

Programs for Handicapped Children, Maryland State Department of Education: 1978 Bylaw 13:04,01.

In accordance with the Education Article, Section: 8-401-409-414 Annotated Code of Maryland, State and local agencies shall provide free and appropriate education programs and related services for all handicapped children from birth through the age of twenty who are found to be in need of special education services.

Definition:

Seriously emotionally disturbed is defined as follows:

1. The term means a condition exhibiting one or more of the following characteristics over a long period of time and to such a degree, that it markedly affects education performance:

a.) an inability to learn which cannot be explained by intellectual, sensory or health factors;

b.) an inability to build or maintain satisfactory interpersonal relationships with peers and teachers;

c.) inappropriate types of behaviors or feelings under normal circumstances;

d.) a general pervasive mood of unhappiness or depression;

e.) a tendency to develop physical symptoms or fears associated with personal or school problems.

The term includes children who are schizophrenic or autistic. The term does not include children who are seriously maladjusted unless it is determined that they are seriously emotionally disturbed.

Regulations of the Commissioner, Part 200,(Revised) State of New York, Code: Ed. 1979: Behavior of Handicapped Children.

Emotional Disturbance

Definition:

A child whose condition has been determined to be such by a school psychologist, psychiatrist or approved mental health unit documented by a description of the behavior that has warranted the decision.

New York State is currently in the process of revising the classification system for the purpose of disposing of popular labels and applying behavioral descriptions in terms of cognitive, emotional and physical aspects of development.

State of Iowa, Division of Special Education, Rules of Special Education (Revised) 1977.

12.1 (257,281 and 442) Scope

p.1

These rules apply to the provision of education and education related services to children requiring special education between birth and 21 (and to a maximum allowable age in accord with section 281.8 of the Iowa Code) who are enrolled in the public schools in the state of Iowa or in non-public schools. In addition, they apply to children who require special education and are being educated at home, in hospitals, or in facilities other than schools, and to persons below or above compulsory school attendance age, to the extent that programs of special education and related services are required or available pursuant to statute for such persons.

p.2

c.) Emotional disability which is manifested as a behavior disorder is a pattern of situationally inappropriate behavior, observed in the school setting which deviates substantially from behavior appropriate to one's age and significantly interferes with the learning process, with interpersonal relationships, or personal adjustment of the pupil. The determination of this handicap is largely based on consistency, intensity, and duration of the behavior of concern.

Rules implementing Subchapter 10 of Chapter 115
Wisconsin Statutes, Department of Public Instruction
Bulletin no. 8357-1978, no. 226

p.126
Emotional Disturbance

1. Classification of emotional disturbance as a handicapping condition is determined through a current, comprehensive study of a child, age 0 through 20, by an *M-Team.

2. Emotional disturbance is characterized by emotional, social and behavioral functioning that significantly interferes wi with the child's total educational program and development including the acquisition or production or both of academic skills, social interactions, interpersonal relationships or intrapersonal adjustments. The condition denotes intraindividual and interindividual conflict or variant or deviant behavior or any combination thereof, exhibited in the social systems of school, home and community and may be recognized by the child or significant others.

3. All children may experience situational anxiety, stress and conflict or demonstrate deviant behaviors at various times and to varying degrees; however the handicapping condition of emotional disturbance shall be considered only when behaviors are characterized as severe, chronic, or frequent and are

manifested in two or more of the child's social systems, e.g.,school,home or community. The M-Team shall determine the handicapping condition of emotional disturbance and further shall determine if the handicapping condition requires special education. The following behaviors, among others may be indicative of emotional disturbance:

a.An inability to develop or maintain satisfactory interpersonal relationships.
b.Inappropriate affective or behavioral response to what is considered to be a normal situational condition
c.A general pervasive mood of unhappiness, depression, or state of anxiety.
d.A tendency to develop physical symptoms, pains or fears associated with personal or school problems.
e.A profound disorder in communication or socially responsive behavior eg.autistic like
f.An inability to learn that cannot be explained by intellectual,sensory or health factors.
g.Extreme withdrawl from social interaction or extreme aggressiveness over an extended period of time.
h.Inappropriate behaviors of such severity or chronicity that the child's functioning significantly varies from children of similar age, ability,educational experience, and opportunity, and adversely affects the child in a regular or special class./

4. The operational definition of the handicapping condition of emotional disturbance does not postulate the cause of the handicapping condition in any one aspect of the child's make-up or social systems.

5. The manifestations of the child's problems are likely to influence family interactions, relationships and functioning or have a specific influence on on certain individual family

members. It is strongly recommended that extensive family involvement or assistance be considered in the evaluation and programming of the child.

The condition of emotional disturbance may be the result of interaction with a variety of other handicapping conditions such as learning, physical or mental disability, or severe communication problems such as speech or language.

7. An M-team referral for suspected emotional disturbance may be indicated when certain medical or psychiatric diagnostic statements have been used to describe a child's behavior. Such diagnoses may include, but not be limited to autism, schizophrenia, psychosematic disorders, school phobia, suicidal behavior,elective mutism, or neurotic states of behavior. In addition, students may be considered for a potential M-team evaluation when there is suspected emotional disturbance, who are also socially maladjusted, adjudged delinquent, drop-outs, drug abusers, or students whose behavior or emotional problems, are primarily associated with factors including cultural deprivation, educational retardation, family mobility, or socio-economic circumstances, or suspected child abuse.
PI 11.03

* M-Team - Intent. The M team shall determine if the child has a mental, learning or emotional or physical disability and shall determine if special education services are required including the type of service.

APPENDIX D

Compare and contrast the ethical implications of chemotherapy and behavior modification as treatment methodology for emotionally disturbed children.

Thomas Mallon states: "An early period of irrational optomism, characterized by the belief that psychiatric "wonder drugs" would cure all mental illnesses and deplete the rolls of every state hospital, has passes. Their use as "tools in the treatment kit" is rationalized by the exerted effect on the organism. Questions arise as to the precise nature of consequences, e.g. whether the drug produces singly or in combination, motor behavior, sensory processes, perception, discrimination, learning, memory, conceptual thinking and so on." Since answers to the above questions are obtained largely through clinical lab studies on animals, the effect on humans can be obtained only by human clinical trials. Researchers in the field, including Rubin (1962) and Lehmann (1959 conclude that certain chemical agents can best be described in terms of their ability to counteract different patterns of disequilibria among psychophysiological systems through selective excitatory and inhibitory effects. However, there are those who believe that the factors that determine a patient's response are not molecular but are determined by a prior psychological state and the environment in which he currently functions. ie. the meaning the patient derives from the experience, determines the response.

Rubin,1."Patterns of adrenergic-cholinergic imbalance in the functional psychoses." *Psych. Review*, 69 (501-519)1962
Lehmann,H.E."Concepts,rationale, and research."In Kline,N.S. in Kline,N.S.ed. *Phychopharmacology Frontiers*.Boston:Little, Brown,1959.

Probably the most viable alternative to the massive use of "wonder drugs" is the extended and expanded programs of Education and Psychotherapy. Benne, in "The Current State of Planned Changing in Persons, Groups, Communities and Societies," an essay in The Planning of Change, summarizes some of the current popular practices employed to bring about behavioral change.

1. Rogerian counseling; extended from a two-person setting into the encounter group which is an effort to create situations and conditions allowing free persons to learn about themselves and through communication with the therapist and others focus on individual needs and concerns.

2. In Gestalt Therapy attention is focused, usually in the presence of other clients, upon the client's discovery and acceptance of his or her own boundries of self against the boundries of other "selves". Emphasis is placed on individual client ownership of his individual responsibility for personal actions and feelings while disowning responsibility for the feelings and actions of others. Drama, fantasy, and spontaneous exercises are utilized.

3. Transactional analysis is an outgrowth of Freudian analysis.
   Suppressed feelings about the roles of "family members are released through role playing, interpretation is allowed through interaction with others and allows the individual to build and enact more reality-oriented relationships with others.

4. The T- group (Training Group) focus is on helping persons to rediscover themselves and reevaluate themselves as members of groups and of learning to relax and build interpersonal relationships with strangers; sometimes called sensitivity groups, saught to develop awareness of self and others.

5. Clarification group- stimulate members in discovering or rediscovering the social self; who am I, what am I, what can I do, what do I do, how do I think, what do I believe etc. Actually this is a discovery or rediscovery of "body...

Bennis, Benne, Chin, Corey. The Planning of Change. 3rd. ed. New York: Holt, Rinehart and Winston: 1975

The three major criteria that have been employed in classifying psychopharmacological drugs are:

1.chemical composition
2.neurological site and mode of physiochemical action
3.effects on clinical behavior and mood

A great deal of research has been conducted in the last decade and information obtained as to the possible value derived from the use of the "wonder agents", however it has not been convincingly demonstrated that they can "cure". In the research of Davis(1965) tranquilizers and antidepressants proved highly superior to other drugs in psychotic populations. Minor tranquilizers appear to be valuable in relieving anxieties.

The responsibility for the dispensation of drugs to aid or alter the condition of a patient remains with the medical personnel who operate within legal, moral and ethical guidelines.

Consent of parents or those serving "in loco parentis" is required before treatment is administered. Education for use and instructions for dealing with side effects of medications prescribed are also the responsibility of those persons prescribing their use.

Experimental use, in a clinic situation is closely monitored by staff, allows for adequate and proper dosage and elimination of the use at an appropriate time. For those individuals who fear the possibility of addiction, decreased benefits following long term usage, adverse side effects, progressive increases in dosage to accommodate greater physical growth an alternative to the use of "wonder drugs" must be provided.

APPENDIX E

In what ways could a comprehensive psychoeducational evaluation by a psychologist aid the differential diagnosis of the emotionally disturbed child?

1.1
A comprehensive diagnosis would include background information, results of prior testing,(academic and psychological), medical history, social history and results of current testing.

1.2
Current testing will include but not be limited to:
  academic areas (standardized tests)
  academic areas (criterion referenced tests)
  mental abilities
  hearing (screening: auditory discrimination)
  visual perception
  speech and language development (when appropriate)
  self rating scale (self image)
  personality inventory
Current assessments will include:
  behavioral checklists
  personality scales
  autobiography
Interviews
  with the child.
  with anyone having contact with the child in his routine.
Observations
  made objectively in as many different social situations as possible.
  of the child alone
  of the child with an animal
  of the child with an inanimate object

1.3
A composite picture of the current functioning level of the child will be obtained when the results are recorded from the information obtained.

1.4
Information derived from test results and informatiion obtained from other sources provides baseline data from which the teacher (and other team members) may construct an IEP (Individualized Education Plan).

a) Information obtained from the medical report will alert him/her to possible side effects of medication, or limitations of activity recommended

b) The hearing screening (such as Wepman's auditory discrimination test) will give a gross indication of loss and indicate need for services of an audiologist

c) Results of the ITPA (Illinois Test of Psycholinguistic Abilities) will provide information relevant to program planning for speech and language development.

d) Lincoln-Oseretsky Motor Skills Development test will provide provide a motor development age.

e) The Beery or Frostig Test of Visual Perception aids in detecting weakness in visual perception and may indicate referral to an ophthalmologist.

f) Mental Testing(Wisc.R., Stanford Benet)provides an I.Q. and analysis of sub-test results may be useful, when compared with other measures in determining organicity or in determining strengths and weakness areas.

g) Use of the BenderGestalt or Benton Visual Retention Test may aid in making a differentiation between organic dysfunction and maturational lag.

h) Behavior rating scales (such as Burke's) completed by teachers in different subject matter areas may help to pinpoint behavior traits or patterns and the degree of intensity.They may also reveal teacher-student personality conflict. Student self- rating on a scale such as this may aid in determining "how the child views himself".

i) Student drawings (family, house-tree- person,self) may be utilized and interpreted with relevant results.

1.4 (continued)

Examining all developmental aspects of the emotionally disturbed child (physical, mental, social, emotional, and educational) aids the diagnostician in determining the nature of the child's difficulties and this information when presented meaningfully to the teacher should affect not only the child's educational plan but will influence his/her perception of the "total individual".

1.5

Teacher expectations should be influenced by the information obtained from psychoeducational testing and assessments.

a) ability level will determine grade placement in each subject matter area .

b) emotional status will determine frustration tolerance levels (affect quantity of work)

c) emotional status will determine the need for specialized behavior modification techniques

d) emotional status will indicate the degree of "ego damage" and aid in rehabilitation planning

e) physical condition may require monitoring of medication in-take

f) social status will influence curriculum content and specialized techniques for replacing unsocialized tendencies with socially acceptable behaviors

1.6

Different methods of treatment are required for different conditions of malfunctioning; therefore it is imperative that an accurate diagnosis is made to determine causal factors which interrelate (rarely is a single factor responsible) to produce maladaptive behaviors manifested by the severely emotionally disturbed child.

APPENDIX F

Teacher comments on personal opinions and feelings about working with children who are emotionally disturbed (by geographical area: Northeastern /Middlewestern

Random samples of teacher comments

Northeastern

1. You need to know them; care about them; let them know this.
2. Find out what does work with the child; learn what he/she responds to then use it to meet your own goals .
3. Let them know that you are the authority, but reasonable.
4. Show them respect if you want their respect.
5. I would like to be aware, when the child comes to me, of special problems that have surfaced in the past; information on I.Q., home problems, things that "trigger" the child etc. it would cut down on trial and error work.
6. I would really like to "uncover"the child's real problems and then use my own ideas.
7. Feelings should be validated--the child should know you understand how he/she is feeling and that it is all right.
8. The child should be supported as a "whole person"--he should know that his problem should not impair that.
9. I found working with these children very hard.
10. It is very important to have staff working with you to help, when working with children with emotional problems.
11. Children who are emotionally disturbed should be with normal children as much as possible.
12. The family must be involved, the school cannot solve the problems. The school can be a source of help for the home.
13. They need help and I want to help them but it's very, very discouraging; I so often feel that I've made no lasting change after I have tried for a considerable length of time to get results.
14. Any approach must include working with the entire family.
15. Parents especially need support and encouragement so that they can gain feelings of competence.
16. You should get as much information as you can on the child in order to help him/her.
17. Individualize the materials; relate to the child's needs.
18. Be well organized; structure all classes and materials.
19. Be firm but understanding of student problems.
20. It's a difficult field to work in; I won't be able to stay.

21. It is sometimes hard to convince other teachers or M-team members that the etiology of a child's problem may be emotional rather than the result of a learning defect especially if he is placed in a L.D. situation.
22. These uncaring, unmotivated, resistant children we are working with need educational therapy as well as behavioral control and most teachers with text-book training are not oriented to deal with the type of behaviors they encounter.
23. You must know the problems and then proceed with a program that will work in a positive manner.
24. Use firmness in implementing any objective; be pragmatic.
25. My problem is trying to work tactfully with parents when the parents also need a behavioral control program.
26. I think when kids are in a classroom with kids who do not have inate ability to control their aggression the whole class deteriorates.
27. I feel that we often meet "bleeding heart psychologists" who cannot look at some children objectively; they are frequently manipulated themselves by these bright, clever, unmotivated children.
28. It is difficult to find motivation activities in a classroom setting which is highly structured to allow for concentration and to maintain control; the remediation process is usually slow.
29. If constant reinforcement of acceptable behavior does, after a period of time appear to bring about positive behavioral changes, then the same type of program must be carried out in the community setting after the child has been released from residential treatment.
30. I feel that withdrawn, apathetic behavior is more difficult to work with and to change than is overt aggressive behavior.

Random samples of Teacher Comments

Middlewestern

1. Progress measured by total growth is very difficult; two steps forward, one step back; one step forward two steps back---highs and lows.
2. These children need a great deal of both educational help and emotional help.
3. Work must begin at an early age to be truly effective; I often feel very frustrated-kids fall apart behaviorally, so much vulgar, 3-d. talk; they slip back into old habits so easily when you think progress has been made.
4. Many of these kids are very rough kids; impulsive and sometimes dangerous; it's not a job for the "faint heart!"
5. Very strenuous work; the individual teacher needs to be strong and have strong convictions about the work to stay.
6. Social problems are so severe that academic work usually seems secondary.
7. Some of the older students show very little hope for school progress.
8. No followup on the outside seems to make the work of the Team rather futile.
9. These children need to develop "awareness;" so many of them do not seem to know or understand the *what* and *why* of the world around them.
10. These children need an individual working relationship to help them understand themselves and others.
11. The "total child approach" can best be applied in a clinic or residential setting--public school classes usually are too large to allow for help and the children cannot tolerate the stress even when much encouragement is given.
12. When in a group the kids tend to "trigger" each other; they have difficulty with trust, and identification.
13. The number of children in a classroom must be small.
14. These children have very short attention spans, older children sometimes have spans that compare with very young children.
15. Some of the children have been badly damaged by misunderstanding and need a program to rebuild or to build for the first time a feeling of self-worth.
16. These children have very low frustration tolerance and usually lack impulse control, causing a great deal of difficulty. They do not respond to the normal control methods usually employed in a public school.
17. Without medication, some of these children could never be contained in a group situation.
18. Give encouragement and praise even for small improvements.
19. Give the children a reason to feel "worthwhile", they have developed much personality damage.

20. Iwould like to know more about the side effects of medication and what to expect from the students; some days students fall asleep and some days they do not seem to respond to it at all.

21. I find boys behavior to be more gross and overt aggressions are more open while girls tend to be more adept at sneakiness and concealing their misbehaviors.

22. So many of our children have been punished so much in the past that it is difficult for them to trust adults; there really must be a strong emphasis on the positive.

23. It is a challenging job; it takes a lot of understanding of the child to know how much pressure he can take; stress must be reduced, but you cannot allow a lax atmosphere which produces apathy.

24. These children seem to react better to activities where they can see the results of their work, such as the arts, crafts, science projects etc.

25. Someone has to care about these children or they will be lost to society; I want to help them, but the work leaves me exhausted and without a feeling of accomplishment for my efforts.

26. Because these children do not like themselves, it is difficult for them to really care about others.

27. Motivation is the key; many of the children can be helped if the right methods and materials are used in working with them.

28. The teacher must have a strong personality, not necessarily a large physical size; however, it is essential to have more than one person in the classroom area at all times.

29. So many times the children are not aware of the dangers involved in the behavior that they display.

30. Teachers need as much information as they can get about the child if she/he is going to help solve the problems.

VITA AGATHA ANN WEEPIE DATE: April,1980

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CREDENTIALS FILE

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52242

EDUCATIONAL PREPARATION

High School, Independence, Iowa	1942 Grad.		
Iowa State Teacher's College	1942 Summer		
University of Iowa, Iowa City	1962 B.A.	Major:	Education
University of Iowa, Iowa City	1965 M.A.		Spec. Ed./Psyc.
University of Iowa, Iowa City	1972 Ed S.		Psychology
University of Oregon, Ext. Portland, Oregon	1950-51 Summer		
Syracuse University, Syracuse, New York	1964 Summer		

PSYCHOLOGY INTERNSHIP

Mental Health Institute, Independence, Iowa	1972 (Clinic)
Joint County: Marshall & Poweshiek -Iowa	1973 (School)
Psychology Institutes: Menninger Foundation	1976
Ellis Training	1975
DPI:State of Iowa	1976-78

TEACHING EXPERIENCE

Period: 1942-73

Kindergarten-Primary
Elementary- Junior High
Senior High (Bus. Math & Gen. Science)
Special Education: Physically Handicapped
Mentally Handicapped
Emotionally Handicapped
Learning Disabled

Location: Iowa & Washington States

SCHOOL PSYCHOLOGY EXPERIENCE

K-Senior High Public & Private Schools
Infant - Adult Services: Handicapped

Area Education Agency # 16 Iowa

1974-79

VOLUNTEER OR RELATED EXPERIENCE

Red Cross
University Hospital School
MR:Special Olympics & Bluebird Groups
UCP /Cancer/ Muscular Distrophy/ MS Drives

PROFESSIONAL ORGANIZATIONS

American Psychological Association
Iowa Psychological Association
American Association on Mental Deficiency
Council for Exceptional
NEA : Life
Am. Association of Univ. Women

POSITION DESIRED

PSYCHOLOGY/Education/Clinic